COUNCIL CHAMBER
122981
December 12, 2012

WHEREAS, the City of Dallas desires to continue the self-insured Exclusive Provider Organizations, and fully-insured Medicare Supplement, Medicare HMO and Medicare Part D Prescription plans, third-party administered employee and retiree benefits plans for active employees, retirees, and their eligible dependents for the 2013 Plan Year; and

WHEREAS, the City of Dallas desires to continue as part of the employee Master Plan for eligible employees to receive favorable tax treatment of premiums or medical expenses paid for employee health care, dependent health care, vision and dental coverage, dependent care and non-reimbursed medical expenses; and

WHEREAS, the City of Dallas desires to adopt the employee 2013 Master Plan (self-funded Exclusive Provider Organizations and the 2013 retiree Master Plan to include self-funded Exclusive Provider Organizations for pre-65 retirees and fully-insured Medicare Supplement, Medicare HMO and Medicare Part D Prescription plans) for retirees over 65.

NOW THEREFORE,

BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF DALLAS:

Section 1. That the attached 2013 employee and retiree Master Plans (self-funded Exclusive Provider Organizations and fully-insured Medicare Supplement, Medicare HMO and Medicare Part D Prescription plans) to offer employees and retirees health benefits and first dollar coverage for urgent care services at Concentra's off-site locations be approved.

Section 2. That this resolution shall take effect January 1, 2013 after its passage in accordance with the provisions of the Charter of the City of Dallas, and it is accordingly so resolved.

APPROVED BY
CITY COUNCIL

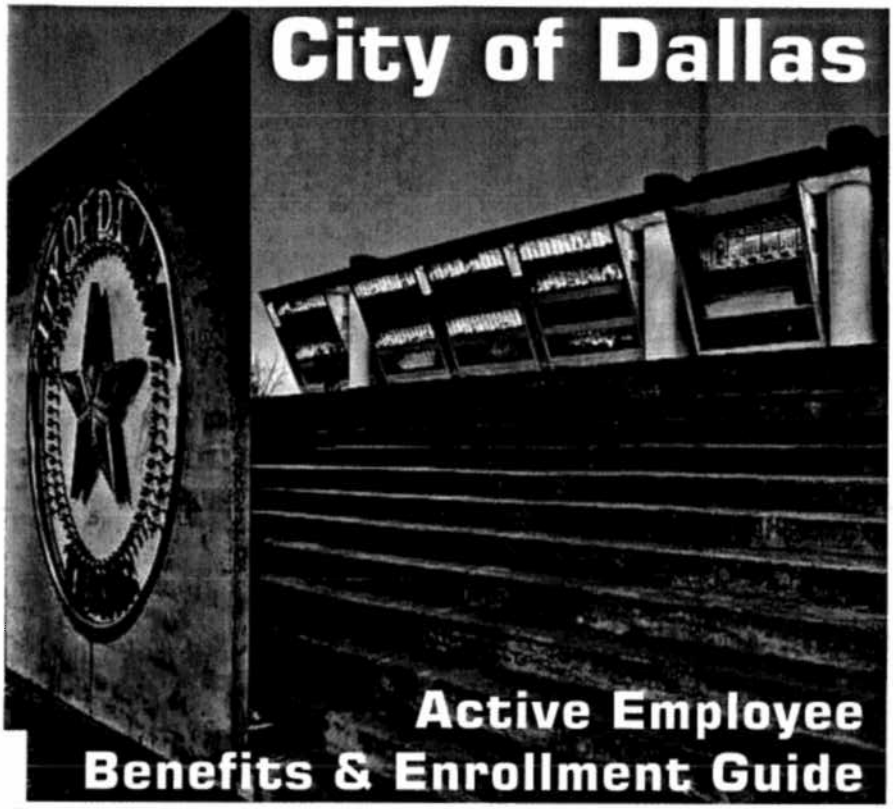
DEC 12 2012

City Secretary

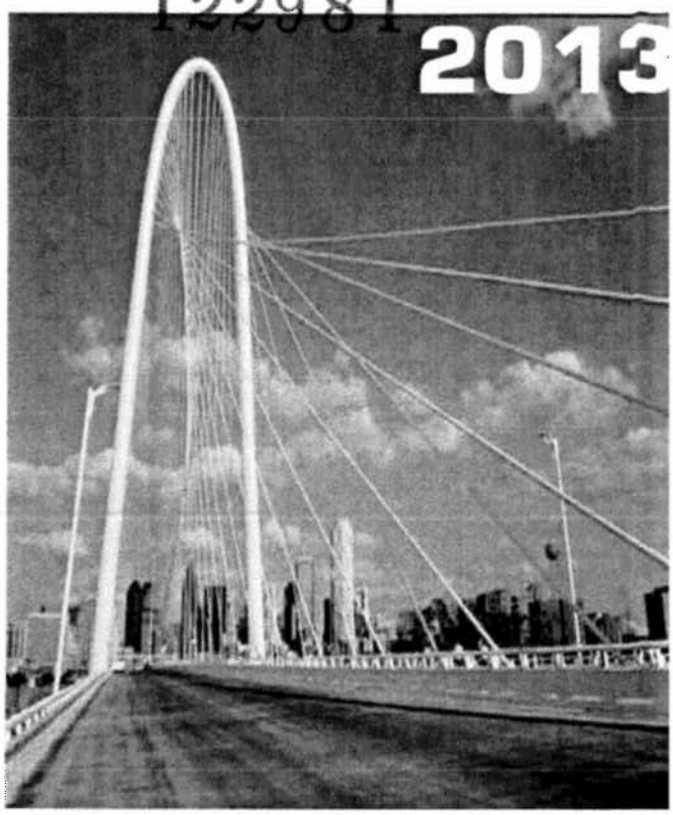
122981

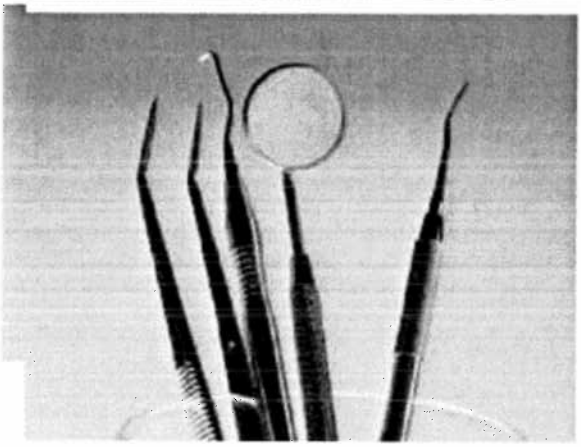
City of Dallas

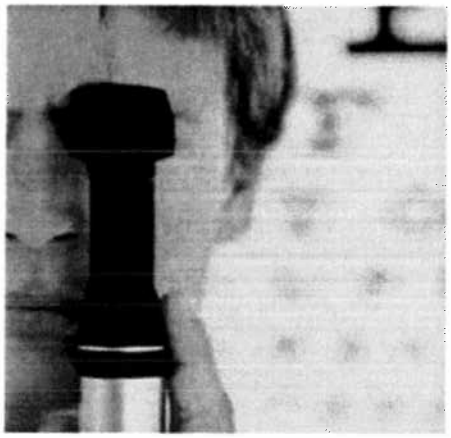
2013



Active Employee Benefits & Enrollment Guide







Human Resources Department
Benefits Service Center

City of Dallas

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Summary of Benefits and Coverage

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format to help you compare across options.

The SBC is available on the Web at: **http://dallascityhall.com/human_resources/benefits_employees.html** and **www.cityofdallasbenefits.com**. A paper copy is also available, free of charge, by calling 1-888-752-9122.

122981

City of Dallas

Welcome to Benefits 2013!

Greetings, Fellow Employee:

It is my pleasure to welcome you to the 2013 Open Enrollment. The City of Dallas provides an annual open enrollment period for employees to review their benefits coverage and make new elections for the upcoming year.

Important things to know for this year's Open Enrollment:

- The Open Enrollment period for 2013 starts **October 1, 2012**, and ends **November 2, 2012**.
- Open Enrollment will be **passive**
  - ◊ You do not have to participate if you do not plan to make any changes to your current benefits plan. Your Medical, Dental, Vision, Basic Life Insurance, Supplemental Life Insurance, Dependent Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance will automatically roll over into the new plan year.
  - ◊ A Flexible Spending Account (FSA), which includes the Employee Medical Spending Plan (EMSP) and the Dependent Care Assistance Plan (DCAP), **cannot roll over**. You must renew your FSA each year to continue to receive this benefit.
- To make changes to your benefit plan elections or enroll in an FSA plan for 2013, you must re-enroll during Open Enrollment. There are three ways to enroll:
  - ◊ Enroll online through Lawson HRIS
    - * You may view and/or make changes to your benefits plan via Lawson's online Web portal. Go to https://hris.dallascityhall.com/lawson/portal; you have 24/7 access to this site from any computer with Internet access.
    - * Use your network ID and password to access the portal.
  - ◊ Call the Benefits Service Center (BSC) at 1-888-752-9122.
  - ◊ Visit the BSC at Dallas City Hall, Room 1DS (Hours: Monday-Friday, 8:15 a.m. to 5:15 p.m.)
- If you need to add or delete dependents, please contact the BSC at 1-888-752-9122. Be sure that you have the required documentation to add your dependents. You may also fax your documents to 1-888-202-5571; please include your name, employee ID number and a call-back number on each faxed page to process your request.

What's New for 2013?

New Flexible Spending Account Guidelines for 2013

The Internal Revenue Service (IRS) has released new guidelines regarding the limits on annual contributions to health FSAs. **These new guidelines will take effect January 1, 2013**. Under the Patient Protection and Affordable Care Act (PPACA) or health care reform, the amount of contributions to a health FSA will be limited to **$2,500** annually. This new guideline will only affect the **Employee Medical Spending** FSA. The maximum annual contribution to the Dependent Care FSA will remain at $5,000.

New Vision Plan Options

The City of Dallas will offer two Vision plan options for 2013. There is the **Standard Plan**, which has not been altered from last year's plan, and the new **Buy-up Plan**. The Buy-up Plan will include the following additional lens options: polycarbonate lenses and standard anti-reflective coating. Polycarbonate lenses are impact-resistant lenses that are often utilized in children's eyewear. Standard anti-reflective coating will aid in glare reduction. There is also an out-of-network laser surgery benefit included with the Buy-up Plan.

New Open Enrollment Website

The City of Dallas has launched a new website to make the Open Enrollment process easier. You can get important information about benefits and the Open Enrollment process by visiting www.cityofdallasbenefits.com. This interactive portal offers you 24/7 access to benefits plan details, important notifications and tutorials to simplify the annual enrollment process.

The Enrollment and Benefits Guide provides details about your benefit options. Reviewing the material contained in this guide will help you make informed decisions about your benefits for 2013. If you have any questions, refer to the vendor contact information section to access our service providers.

As always, I hope you will continue to be pleased with these programs and services as we endeavor to maintain a competitive benefits package for you and your family.

Sincerely,

Molly McCall, Human Resources Director

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Who is Eligible?

You may elect health coverage for you and your eligible dependents during the annual Open Enrollment period and through special enrollments as a result of a Qualifying Life Event. Eligible dependents include the following:

Type of Eligible Dependent	Required Documentation
Spouse (Person of opposite gender)	❖ Copy of Marriage License, Copy of Social Security Card, and Date of Birth If Common-Law Marriage applies, please provide the common-law form* and copies of documentation showing that you and your spouse have lived together for at least six months (provide two documents from list below). Examples include copies of: ❑ Lease or deed naming both partners ❑ Joint checking account statement ❑ Utility bills and/or credit accounts ❑ Will and/or life insurance policies
Domestic Partner (Person of same gender)	❖ Domestic Partner Form** and copies of documentation showing that you and your partner have lived together for at least six months (provide two documents from list below). Examples include copies of: ❑ Lease or deed naming both partners ❑ Joint checking account statement ❑ Utility bills and/or credit accounts ❑ Will and/or life insurance policies ❖ Copy of Social Security Card, and Date of Birth
Dependent Child: Child who is married or unmarried, under age 26 and is the biological child, legally adopted child or stepchild of you and/or your spouse, domestic partner or common-law spouse **Dependent Grandchild (Tax-dependent for current year):** Grandchild who is married or unmarried, under age 25 and is the biological grandchild of you and/or your spouse, domestic partner or common-law spouse	❖ Copy of Birth Certificate showing you as a parent, or ❖ Copy of Adoption Agreement, or ❖ Copy of court custody or guardianship documents, or ❖ Copy of the portion of the divorce decree showing the dependent, or ❖ Copy of Qualified Medical Court Support Order (QMCSO), and ❖ Copy of Social Security Card

*For the Common-Law Spouse Form, go to http://www.dallascounty.org/department/countyclerk/marriage-license.html.
**For the Domestic Partner Form, contact the Benefits Service Center at 1-888-752-9122.
Please note: Your dependents (spouse and/or children) cannot be covered on a plan if you are not covered.

Making Changes to Your Benefits During the Year (Outside the Open Enrollment Period)

In order for your benefits to be effective for the 2013 plan year (starting January 1, 2013), the Internal Revenue Service (IRS) requires that you make benefits elections during our annual Open Enrollment period. You may not change your benefits elections after Open Enrollment unless you experience a **Qualifying Life Event**, which may include:

- Marriage
- Divorce, Legal Separation or Annulment
- Birth or Adoption of an Eligible Child
- Change in your (or your spouse's) work status that affects benefits eligibility (e.g., change from full-time to part-time employment status)
- A change in your child's benefits eligibility
- A Qualified Medical Child Support Order

You must report your Qualifying Life Event to the Benefits Service Center **within 30 days** of that event with the required documentation to support your claim. If you fail to report your Qualifying Life Event within the required timeframe, you must wait until the next annual Open Enrollment to change your benefits elections.

If your dependent does not meet the current eligibility rules during the specified period, and/or you do not provide the required documentation, your dependent(s) will not be added to your benefits plan.

Reminders

To enroll in a benefits plan or change your current plan, please remember:

1. New employees have 30 days from their hire dates to enroll in a benefits plan; otherwise, they must wait until Open Enrollment or have a Qualifying Life Event.
2. The Open Enrollment period for 2013 starts **October 1, 2012**, and ends **November 2, 2012**.
3. You must report a Qualifying Life Event **within 30 days of that event** to change your benefits plan.

Your Core Benefit Choices

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Benefit/Vendor	Funding	Options
Medical (UHC) **Pharmacy (CVS/Caremark)**	City & Employee Contributions	Two Options: ❖ EPO—70/30/3000 ❖ EPO—75/25/HRA
Dental (UHC)	100% Employee Paid	Three Options: ❖ HMO ❖ PPO (Indemnity) ❖ EPO
Vision (UHC)	100% Employee Paid	Two Options: ❖ Standard Plan ❖ Buy-up Plan* Exams: $10 co-payment Materials: $25 co-payment
FSA (UHC) **Employee Medical Spending FSA** **Dependent Care FSA**	100% Employee Paid	 $2,500 maximum** $5,000 maximum
Life Insurance **Basic Life** **Supplemental Life** **Dependent Life** **Accidental Death & Dismemberment**	 100% City Paid 100% Employee Paid 100% Employee Paid 100% Employee Paid	 $50,000 per FT employee Up to three times annual salary ($500K max) Two Dependent Life Options: **(Option 1)** $15K for spouse; $5K per child **(Option 2)** $25K for spouse; $10K per child $25K-$250K

*The City of Dallas will offer two Vision plan options for 2013. There is the Standard Plan, which has not been altered from last year's plan, and the new Buy-up Plan. The Buy-up Plan will include the following additional lens options: polycarbonate lenses and standard anti-reflective coating. Polycarbonate lenses are impact-resistant lenses that are often utilized in children's eyewear. Standard anti-reflective coating will aid in glare reduction. There is also an out-of-network laser surgery benefit included with the Buy-up Plan.

The Internal Revenue Service (IRS) has released new guidelines regarding the limits on annual contributions to health FSAs. **These new guidelines will take effect January 1, 2013. Under the Patient Protection and Affordable Care Act (PPACA) or health care reform, the amount of contributions to a health FSA will be limited to **$2,500** annually. This new guideline will only affect the **Employee Medical Spending** FSA offered through the City of Dallas.

EPO 70/30/3000 Medical Plan Comparison Chart (In-Network Benefits Only) 122981	
Total Deductible	$3000 (single) $9000 (with dep(s)
HRA Allocation (City $$)	N/A
Deductible (Your $$)	Same as Total Deductible
Coinsurance	Member pays 30% Plan pays 70%
Preventive Services (See SPD for Injections)	Plan pays 100%
Outpatient Services	Plan pays 70% after deductible
Inpatient Services	Plan pays 70% after deductible
ER Services at hospital (See SPD for Ambulance services)	$100 Copay plus plan pays 70% after deductible
Specialist Services & Urgent Care Services	Plan pays 70% after deductible
Out-of-Pocket Max (OOPM)	$7500 (single) $15000 (with dep(s)
Rx Coverage (CVS/Caremark):	
Deductible	$150/person
Generic (31 days)	10% or $10 minimum
Preferred (31 days)	25% or $25 minimum
Non-Preferred (31 days)	40% or $40 minimum
Out-of-Pocket Max	$2500/person

EPO 70/30/3000 Medical Plan Monthly Rates (Non-Tobacco User)		
Full-Time Employee Rates	**Health Assessment Completed**	**Health Assessment NOT Completed**
Employee Only	$44	$54*
Employee + Spouse	$351	$361*
Employee + Child(ren)	$119	$129*
Employee + Family	$459	$469*
Permanent, Part-Time Employee Rates		
Employee Only	$107	$117*
Employee + Spouse	$335	$345*
Employee + Child(ren)	$221	$231*
Employee + Family	$480	$482*^
*There is a $10 monthly surcharge for non-tobacco users who did not complete the online health assessment. ^Premium increase applied to the plan at the maximum allowable charge		

EPO 70/30/3000 Medical Plan Monthly Rates (Tobacco User)[1]		
Full-Time Employee Rates	**Health Assessment Completed**	**Health Assessment NOT Completed**
Employee Only	$64	$74*
Employee + Spouse	$369^	$369*^
Employee + Child(ren)	$139	$149*
Employee + Family	$479	$482*^
Permanent, Part-Time Employee Rates		
Employee Only	$127	$137*
Employee + Spouse	$355	$365*
Employee + Child(ren)	$241	$251*
Employee + Family	$482^	$482*^
[1]Tobacco users pay a higher monthly premium rate for their medical benefits. *There is a $10 monthly surcharge for tobacco users who did not complete the online health assessment. ^Premium increase applied to the plan at the maximum allowable charge		

Note: Pharmacy deductible is not included in the medical (OOPM) for the EPO 70/30/3000 Plan.

EPO 75/25 HRA Medical Plan Comparison Chart
(In-Network Benefits Only)

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	HEALTH ASSESSMENT COMPLETED	HEALTH ASSESSMENT NOT COMPLETED
Total Deductible	$2500 (single)	$2500 (single)
HRA Allocation (City $$)	$1000 (single)	$700 (single)
Deductible (Your $$)	$1500 (single)	$1800 (single)
Total Deductible	$5000 (with dep(s)	$5000 (with dep(s)
HRA Allocation (City $$)	$2000 (with dep(s)	$1700 (with dep(s)
Deductible (Your $$)	$3000 (with dep(s)	$3300 (with dep(s)
Coinsurance	Member pays 25% Plan pays 75%	Member pays 25% Plan pays 75%
Preventive Services (See SPD for Injections)	Plan pays 100% (in-network only) doesn't reduce HRA	Plan pays 100% (in-network only) doesn't reduce HRA
Outpatient Services	Plan pays 75% after deductible	Plan pays 75% after deductible
Inpatient Services	Plan pays 75% after deductible	Plan pays 75% after deductible
ER Services at hospital (See SPD for Ambulance services)	Plan pays 75% after deductible	Plan pays 75% after deductible
Specialist Services & Urgent Care Services	Plan pays 75% after deductible	Plan pays 75% after deductible
Out-of-Pocket Max	$6000 (single) $12000 (with deps)	$6000 (single) $12000 (with deps)
Rx Coverage (CVS/Caremark):		
Deductible	Same as (Your $$) Deductible above	Same as (Your $$) Deductible above
Generic (31 days)	10%	10%
Preferred (31 days)	25%	25%
Non-Preferred (31 days)	40%	40%

EPO 75/25 HRA Medical Plan Monthly Rates (Non-Tobacco User)

Full-Time Rates	Health Assessment Completed	Health Assessment NOT Completed
EE Only	$80	$90
EE + Spouse	$448	$458
EE + Child(ren)	$226	$236
EE + Family	$573	$583
Perm Part-Time Rates		
EE Only	$231	$241
EE + Spouse	$612	$622
EE + Child(ren)	$451	$461
EE + Family	$797	$807

*There is a $10 monthly surcharge for non-tobacco users who did not complete the online health assessment.

EPO 75/25 HRA Medical Plan Monthly Rates (Tobacco User)^

Full-Time Rates	Health Assessment Completed	Health Assessment NOT Completed
EE Only	$100	$110*
EE + Spouse	$468	$478*
EE + Child(ren)	$246	$256*
EE + Family	$593	$603*
Perm Part-Time Rates		
EE Only	$251	$261*
EE + Spouse	$632	$642*
EE + Child(ren)	$471	$481*
EE + Family	$817	$827*

^Tobacco users pay a higher monthly premium rate for their medical benefits.
*There is a $10 monthly surcharge for tobacco users who did not complete the online health assessment.

CVS Caremark Prescription Benefit Program 122981

CVS Caremark administers your prescription benefit, which is designed to provide you quality pharmacy care that will help you save money. The information provided below is a brief summary of your prescription benefits. CVS Caremark and the City of Dallas are confident you will find value with your prescription benefit program.

Your plan is based on a combined deductible of medical and prescription claims. The deductible is the total "out-of-pocket" spending required by you before prescription benefits are paid. Your annual deductible is for an individual or a family. Until this deductible amount is met, you will pay 100 percent for your prescriptions.

Find more information about your pharmacy program at www.caremark.com. Call 1-855-465-0023 to obtain a copy of the new prescription drug list (PDL), a mail order form for new mail order prescriptions and other important information including the Specialty Pharmacy Program.

	75/25 HRA Plan		70/30 Plan	
	CVS Caremark Retail Pharmacy Network For short-term medications (up to a 31-day supply)	**CVS Caremark Mail Service Pharmacy** For long-term medications (up to a 90-day supply)	**CVS Caremark Retail Pharmacy Network** For short-term medications (up to a 31-day supply)	**CVS Caremark Mail Service Pharmacy** For long-term medications (up to a 90-day supply)
Generic Medications	10% for a generic prescription	10% for a generic prescription	10% ($10 min) for a generic prescription	10% ($10 min) for a generic prescription
Preferred Brand-Name Medications	25% for a preferred, brand-name prescription	25% for a preferred, brand-name prescription	25% ($25 min) for a preferred, brand-name prescription	25% ($25 min) for a preferred, brand-name prescription
Non-Preferred, Brand-Name Medications	40% for a non-preferred, brand-name prescription	40% for a non-preferred, brand-name prescription	40% ($40 min) for a non-preferred, brand-name prescription	40% ($40 min) for a non-preferred, brand-name prescription
Refill Limit	None	None	None	None
Annual Deductible	$2,500 (Individual); $5,000 (Family)		$150 (Individual)	
Maximum Out-of-Pocket	$6,000 (Individual); $12,000 (Family)		$2,500 (Individual)	
Web Services	Register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your prescription card ready.			
Customer Care	Visit www.caremark.com or call toll-free at 1-855-465-0023.			

Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with any balance paid by a Plan.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

Flexible Spending Account (FSA)

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What is a Flexible Spending Account?
A Flexible Spending Account (FSA) is a tax-free account that allows you to pay for essential health care expenses that are not covered, or are partially covered, by your medical, dental and vision insurance plans; or pay for child/dependent care expenses. You save money to pay for your out-of-pocket healthcare expenses, including prescription drug costs, medical, dental, vision and hearing expenses and/or your child or dependent care expenses, including day care, and before- and after-school care expenses.

How does it work?
- You decide how much you want to deduct from your paycheck before federal, state or Medicare taxes are calculated.
- You reimburse yourself from the account as you pay for eligible health care or dependent care expenses.

You save money by reducing your taxable income. It is that simple.

City of Dallas employees have two FSA options: the **Employee Medical Spending FSA** and the **Dependent Care FSA**.

What you can pay for with a Employee Medical Spending FSA:
You can find a list of eligible expenses at myuhc.com® or see your benefit plan information. Some sample expenses are:

- Your share of health plan expenses, such as deductibles and copayments (insurance premiums do not qualify)
- Eyeglasses and contact lenses
- Dental work, orthodontia and dentures

You can no longer use your Employee Medical Spending FSA for over-the-counter (OTC) medicines or drugs without a prescription. This change was part of the Affordable Care Act passed in 2010.

(Effective January 1, 2013)
The maximum annual contribution to your Employee Medical Spending FSA will be $2,500.

You can use your Dependent Care FSA to pay for:
- Daycare services for children under age 13
- Care for other qualifying dependents who are unable to care for themselves

Dependent Care FSA is for dependent daycare only. It is not to be confused with dependents' health care expenses, which should be considered in your calculation of your Employee Medical Spending FSA contributions.

The maximum annual contribution to your Dependent Care FSA is $5,000.

You have more time to spend your FSA dollars.
The federal government now allows a "grace period" to give you more time to use your FSA dollars. This grace period reduces any worry if you have FSA dollars remaining at the end of the plan year.

How long is the grace period?
Two and one-half months after your calendar year plan ends. You have until March 15, 2014 to use your 2012 FSA dollars on eligible expenses. **All claims must be submitted by March 31, 2014.**

What about the "use it or lose it" rule?
This rule still applies. However, having a grace period allows you to use the remaining funds until March 15, 2014.

All claims must be submitted by March 31, 2014.

There are a few ways to access your FSA funds that can save time and paper; they can also reduce the wait time to receive reimbursements.

1. When UnitedHealthcare processes your claim (medical, dental or vision) or CVS Caremark processes your pharmacy claim, the patient responsibility on the claim will "roll over" to the FSA account. As long as there are available funds, you will receive a reimbursement from your FSA account. Please note, if you are also enrolled in the HRA Medical Plan, the medical claim will roll over to your HRA account first and then to your FSA account after your HRA funds have been used.
2. Your FSA will also come with a convenient Consumer Accounts MasterCard® that allows you to pay for eligible expenses anywhere that MasterCard® is accepted.
3. All other eligible expenses would require you to file claims for reimbursements. However, you can sign up for Direct Deposit using the "Account Settings" on www.myuhc.com. This allows your FSA reimbursements to be automatically deposited into your savings or checking account.

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Prorated HRA Funds
(Based on the month of enrollment)

Month	Employee Only	Employee & Dependents
January	$700.00	$1,700.00
February	$641.67	$1,558.33
March	$583.34	$1,416.66
April	$525.01	$1,274.99
May	$466.68	$1,133.32
June	$408.35	$991.65
July	$350.02	$849.98
August	$291.69	$708.31
September	$233.36	$566.64
October	$175.03	$424.97
November	$116.70	$283.30
December	$58.37	$141.63

If you enroll as a New Hire or experience a Qualifying Life Event (QLE) after January 31, the funds allocated to your account balance will be reduced based on the table above.

Concentra TotalCare Health and Wellness Center

Concentra TotalCare Health and Wellness Center is the on-site medical clinic located at Dallas City Hall. The center offers select preventive and diagnostic services to employees and dependents (age 5 and older) covered by the City's health plan at no cost. Employees who are not enrolled in City of Dallas medical plans can also receive treatment at a nominal cost.

On-site Clinic Services for Employees Enrolled in City of Dallas Medical Plans		
Visit Description	**EPO 75/25 HRA Plan**	**EPO 70/30 Plan**
Preventive Care Services • Services provided at onsite clinic • Lab services that are sent out to LabCorp will be processed according to your medical plan benefits.	• No cost to employees or dependents • Paid at 100%	• No cost to the employees or dependents • Paid at 100%
Injury or Illness Care: Diagnostic Services • Service provided at onsite clinic • Lab services that are sent out to LabCorp will be processed according to your medical plan benefits	• No cost to employees or dependents • Services are subject to 25% coinsurance after $2,500 deductible is met; HRA funds will be used if still available	• No cost to employees or dependents • Services are subject to 30% coinsurance after $3,000 deductible is met

Concentra® treated right

Concentra TotalCare Health and Wellness Center | 1500 Marilla, Room 1CS, Dallas, TX 75201
Phone: 214-671-9140 | Fax: 214-749-0412 | Hours: Monday through Friday, 7:30 a.m. to 5:30 p.m.

Dental Plan Overview

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United Healthcare is our provider for dental offerings for 2013. Your options include:

- Dental EPO, which allows you to select the provider of your choice
- Dental HMO, which provides in-network benefits only while having a co-pay schedule
- Dental EPO, which allows you to select the provider of your choice while having a co-pay schedule

Plan Features	UHC PPO		UHC HMO	UHC EPO
	In-Network	Out-of-Network	In-Network Only	
Calendar Year Deductibles • Individual • Family	$50 $150		$0 $0	$50 $150
Maximum • Calendar Year • Orthodontic Lifetime	$1,000 per person N/A		$0 ********	$1,250 $1,500
Visits and Exams • Office visit • Oral Exam • X-rays	You pay 0%	You pay any charges in excess of Allowed Amount*	Office visit: $5 Oral exam: $0 X-rays: $0	Copays vary by service according to Patient Charge Schedule*
Basic Services • Fillings • General Services • Space Maintainers	You pay 0%	You pay 20% and any charges In excess of Allowed Amount*	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*
Major Services • Crowns • Dentures/Bridges	You pay 50%	You pay 50% and any charges in excess of Allowed Amount*	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*
Orthodontic Services	Not Covered	Not Covered	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*

***The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographic area in which the expenses are incurred.*

Monthly Dental Plan Rates			
Coverage Level	Dental PPO	Dental HMO	Dental EPO
Employee Only	$24.13	$7.76	$18.02
Employee + Spouse	$48.27	$14.29	$33.15
Employee + Child(ren)	$49.23	$14.36	$33.32
Employee + Family	$73.39	$20.20	$46.86

Vision Plan Overview

New Vision Plan Options

The City of Dallas will offer two Vision plan options for 2013. There is the **Standard Plan**, which has not been altered from last year's plan, and the new **Buy-up Plan**. The Buy-up Plan will include the following additional lens options: polycarbonate lenses and standard anti-reflective coating. Polycarbonate lenses are impact-resistant lenses that are often utilized in children's eyewear. Standard anti-reflective coating will aid in glare reduction. There is also an out-of-network laser surgery benefit included with the Buy-up Plan.

Monthly Vision Plan Rates		
Coverage Level	Standard Plan	Buy-up Plan
Employee Only	$4.79	$5.76
Employee + Spouse	$8.75	$10.52
Employee + Child(ren)	$9.19	$11.04
Employee + Family	$14.14	$17.01

Vision Plan Overview *(continued)*

122981

Benefit/Service	Standard Plan		Buy-up Plan	
	UHC Network Provider	Out-of-Network Reimbursement[1]	UHC Network Provider	Out-of-Network Reimbursement[1]
Comprehensive Exam (every 12 months)	$10 copay	up to $40.00	$10 copay	up to $40.00
Materials	$25 copay	See spectacle lenses and frame benefit below	$25 copay	See spectacle lenses and frame benefit below
Spectacle Lenses* (every 12 months) Standard Plan: • Standard Scratch-Resistant Coating Buy-up Plan: • Standard Scratch-Resistant Coating • Polycarbonate Lenses • Standard Anti-Reflective Coating	$25 copay	Single Vision up to $40.00 Bifocal up to $60.00 Trifocal up to $80.00 Lenticular up to $80.00	$25 copay	Single Vision up to $40.00 Bifocal up to $60.00 Trifocal up to $80.00 Lenticular up to $80.00
Frames (every 24 months)	$130.00 retail frame allowance	Up to $45.00	$130.00 retail frame allowance	Up to $45.00
Contact Lenses (every 12 months)** • Fitting/evaluation • Contacts • Two follow-up visits (after $25 copay).	Covered-in-full selection or $105.00 allowance	Elective up to $105.00 Necessary up to $210.00	Covered-in-full selection or $105.00 allowance	Elective up to $105.00 Necessary up to $210.00
Laser Vision* **	N/A	N/A	N/A	Lifetime Max Reimbursement of $500

[1]Out-of-Network Reimbursements: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: UHC Vision, ATTN: Claims Dept., P. O. Box 30978, Salt Lake City, UT 84130.

Important to Remember

*Benefits available every 12 to 24 months (depending on the benefit frequency), based on last date of service.

**Your $105 Contact Lens allowance is applied to the fitting/evaluation fees and the purchase of the contact lenses. For example, if the fitting/evaluation fee is $30, you will have $75 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. If you chose disposable contacts, you may receive up to four boxes of disposable contacts (depending on prescription. This benefit is covered in lieu of eyeglasses when obtained from a network provider. Toric, gas permeable and bifocal contacts are all examples that are outside our covered-in-full selection.

***UHC has partnered with the Laser Vision Network of America (LVNA) to provide members with access to discounted laser correction providers (877-25-SIGHT)

Standard Life Insurance Plan Overview 122981

One of the most important things about life insurance is the financial peace of mind it gives you and your loved ones. Standard Life Insurance offers you coverage that allows you to provide for others in the event of your or your dependents' death. You may select from the following options:

- **Basic Life Insurance**: $50,000 basic term life insurance coverage is available to eligible, full-time employees at no cost. No enrollment action is necessary for full-time employees. Part-time employees must contact the Benefits Service Center to enroll and must pay half the cost.
- **Supplemental Life Insurance**: Includes coverage options up to three times an employee's base annual salary—not to exceed $500,000. This product's cost increases as you age. New employees can elect one, two or three times their annual salary.

  Employees who currently are enrolled in supplemental life can only increase their coverage by one increment during open enrollment without submitting evidence of insurability. For example, employees who currently have coverage of one times their annual salary can only increase their coverage to two times their annual salary. If you would like to increase coverage more than one time your salary, you must submit an Evidence of Insurability (EOI) Form. Please contact the onsite representative at Dallas City Hall, Room 1DS, or call 214-670-4181.
- **Dependent Life Insurance**: You may purchase dependent group term life insurance coverage. If you initially decline coverage for your spouse, you are required to provide evidence of insurability to enroll at a later date. Evidence of insurability is not required for children. An employee may not be insured as both an employee and dependent. A child may not be insured by more than one employee.
- **Accidental Death and Dismemberment (AD&D)**: You may purchase 24-hour accident protection. Individual and family plans are available. An employee may not be insured as both an employee and dependent. A child may not be insured by more than one employee. You may elect Voluntary AD&D coverage for your spouse/domestic partner and dependent children. The coverage amount for each dependent is as follows:
  - Spouse/domestic partner only; 60 percent of employee's Voluntary AD&D coverage amount
  - Children only; 20 percent of employee's Voluntary AD&D coverage amount; the amount of AD&D insurance for your child may not exceed $50,000.
  - Spouse/domestic partner and children; 50 percent of employee's Voluntary AD&D coverage amount for the spouse/domestic partner and 15 percent of employee's Voluntary AD&D coverage amount for each child. The amount of AD&D insurance for your child may not exceed $50,000.
- **Beneficiary designation forms** are located on the City of Dallas Intranet/Internet sites under the Life Insurance link.
- **To file a life claim, please call 1-877-474-4250 or 214-670-4181.**
- **Please refer to your insurance policy for additional information.**

2013 Supplemental Life Insurance Monthly Rates

Employee's Age (on last January 1)	Rate (Per $1,000 of Total Coverage)
Less than 25	$0.05
25-29	$0.06
30-34	$0.08
35-39	$0.09
40-44	$0.11
45-49	$0.19
50-54	$0.32
55-59	$0.47
60-64	$0.68
65-69	$1.27
70 and older	$2.25

To calculate your premium:

1. Select Amount: (1, 2 or 3 times your annual salary)
2. Divide by $1,000
3. Select your rate based on your age from the table to the left
4. Multiply line 2 by line 3 to get your monthly rate

Example: (1) $40,000 annual salary / (2) $1,000 - 40 x (3) $0.09 (age 35) = (4) $3.60 per month

Continued on next page

2013 Accidental Death & Dismemberment (AD&D) Monthly Rates

Employee Only

	25,000	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
<70	$0.75	$1.50	$2.25	$3.00	$3.75	$4.50	$5.25	$6.00	$6.75	$7.50
70-74	$0.49	$0.98	$1.46	$1.95	$2.44	$2.93	$3.41	$3.90	$4.39	$4.88
75-79	$0.34	$0.68	$1.01	$1.35	$1.69	$2.03	$2.36	$2.70	$3.04	$3.38
80-84	$0.23	$0.45	$0.68	$0.90	$1.13	$1.35	$1.58	$1.80	$2.03	$2.25
85 +	$0.11	$0.23	$0.34	$0.45	$0.56	$0.68	$0.79	$0.90	$1.01	$1.13

Employee/Family

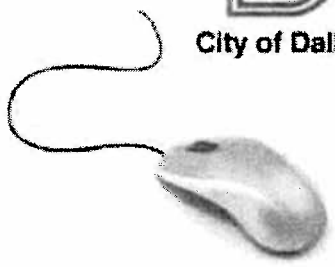
	25,000	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
<70	$1.13	$2.25	$3.38	$4.50	$5.63	$6.75	$7.88	$9.00	$10.13	$11.25
70-74	$0.73	$1.46	$2.19	$2.93	$3.66	$4.39	$5.12	$5.85	$6.58	$7.31
75-79	$0.51	$1.01	$1.52	$2.03	$2.53	$3.04	$3.54	$4.05	$4.56	$5.06
80-84	$0.34	$0.68	$1.01	$1.35	$1.69	$2.03	$2.36	$2.70	$3.04	$3.38
85 +	$0.17	$0.34	$0.51	$0.68	$0.84	$1.01	$1.18	$1.35	$1.52	$1.69

2013 Dependent Life Insurance Monthly Rates

- Option 1: $15,000 for spouse; $5,000 for children to age 25 = $2.85
- Option 2: $25,000 for spouse; $10,000 for children to age 25 = $5.25

City of Dallas

Learn more about your benefits plan at myuhc.com.



The tools and information at myuhc.com are both practical and personalized so you can get the most out of your benefits. Register at myuhc.com and connect to current information about your benefits plan and health care interests.

UnitedHealthcare

It's all at your fingertips online at www.myuhc.com:

1. **Compare costs for different health plans.**
   (Select Plan Cost Estimator located under Links & Tools)
2. **Ask health care professionals.**
   Select Live Nurse Chat on the home page to get one-on-one advice seven days a week online.
3. **Organize your medical claims online.**
   View processed claims, remaining balances for deductibles and out-of-pocket expenses via your Health Statements.
   Arrange automatic payments, direct deposits and more.
4. **Get information about hospitals and physicians.**
   Find in-network doctors based on practice.
5. **Learn more about your coverage.**
   Learn what services are covered by your medical plan.
6. **Organize and store all of your health data in one convenient, confidential place.**
   Record your family medical history and track your health progress.
   Download your personal health summary.
7. **Improve your health habits.**
   Participate in health coaching programs that help set goals to achieve health objectives.
8. **Learn about health conditions and treatment options.**
   (Select Health & Wellness>Conditions AtoZ)
9. **Request a medical ID card.**
   Print a temporary ID card or request a replacement card.

What is COBRA?
The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers with group health benefit plans to offer employees the opportunity to continue temporarily their group health care coverage under their employer's plan if their coverage otherwise would cease due to termination, layoff or other change in employment status (referred to as "qualifying events").

How long must COBRA continuation coverage be available?
- ❑ Up to 18 months for termination or reduction of hours
- ❑ Up to 29 months to employees who are determined to have been disabled at any time during the first 60 days of COBRA coverage and to the disabled employee's nondisabled beneficiaries.
- ❑ Up to 36 months for spouses and dependents due to an employee's death, divorce or legal separation.

What plans are subject to COBRA?
Group health, vision, dental and health care spending account (EMSP) plans are subject to COBRA.

What specific events can be qualifying events?
- ❑ Death of employee
- ❑ Voluntary or involuntary termination of employment (other than by reason of gross misconduct)
- ❑ Retirement
- ❑ Reduction in hours
- ❑ Divorce or legal separation
- ❑ Dependent child ceasing to be a dependent

How much does COBRA cost for City-sponsored plans?

COBRA	70/30/3000 EPO Monthly Rates	75/25/HRA EPO Monthly Rates
Member only	$169	$401
Member + spouse	$369	$788
Member + childr(ren)	$319	$710
Member + family	$482	$1,168

COBRA Monthly Dental Plan Rates			
Coverage Level	Dental PPO	Dental HMO	Dental EPO
Member Only	$24.61	$7.92	$18.38
Member + Spouse	$49.24	$14.58	$33.81
Member + Child(ren)	$50.21	$14.65	$33.99
Member + Family	$74.86	$20.60	$47.80

COBRA Monthly Vision Plan Rates		
Coverage Level	Standard Plan	Buy-up Plan
Member Only	$4.89	$5.88
Member + Spouse	$8.93	$10.73
Member + Child(ren)	$9.37	$11.26
Member + Family	$14.42	$17.35

Women's Health Cancer Rights Act (WHCRA) Enrollment Notice
If you have had or plan to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

The benefits provided are subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like additional information on WHCRA benefits, call your plan administrator at 800-736-1364.

Continuation of Health Coverage During Family and Medical Leave (FMLA)
The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period to eligible employees for certain family and medical reasons. This provision is intended to comply with the laws and any pertinent regulations, and its interpretation is governed by them. See the City of Dallas Personnel Rules to find out how this continuation applies to you.

For the duration of FMLA leave, the employer must maintain the employee's health coverage. The employee may continue the plan benefits for himself or herself and his or her dependents on the same terms as if they employee had continued to work. The employee must pay the same contributions toward the cost of the coverage that he or she made while working. If the employee fails to make the payments on a timely basis, the employer, after giving the employee written notice, can end the coverage during the leave if payment is more than 30 days late. Upon return from a FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms. The use of a FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

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

Important Notice About Your Prescription Drug Coverage & Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Dallas and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City of Dallas has determined that the prescription drug coverage offered by United MedicareRx offered by UnitedHealthcare is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage—through no fault of your own—you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you are enrolled in the City's Active employee or Pre-65 retiree EPO health plan; that coverage pays for medical expenses in addition to prescription drug expenses which are included the plan's design. As a retiree, if you decide to join a non-City of Dallas sponsored Medicare drug plan, your current City of Dallas coverage will be affected as you cannot be enrolled in two plans. If you decide to join a Medicare drug plan as a retiree that is not sponsored by the City of Dallas and drop your current City of Dallas coverage, be aware that you and your dependents will not be able to get this coverage back. *See pages seven through nine of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.*

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with the City of Dallas and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage
Please contact the Benefits Service Center at 1-888-752-9122 or send written correspondence to the address listed at the end of this notice.

NOTE: This notice will be provided in each annual enrollment guide and if this coverage through the City of Dallas changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:
Visit www.medicare.gov
Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty). To receive a copy of this notice, please use the contact information listed below.

City of Dallas – Benefits Department
Benefits Service Center
1500 Marilla Street, 1D-South, Dallas, TX 75201
Phone Number: 1-888-752-9122

CITY OF DALLAS
Notice of Medical Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting Your Personal Health Information
The City of Dallas understands that your health information is personal and private. We are committed to protecting the privacy of your health information and the health information of your family members that we, and the Health Plans we sponsor for the benefit of our employees, receive and maintain. This health information is referred to in this Notice as "your protected health information."
We are required by law—the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA")—to:

- ❑ Make sure that your protected health information is kept private
- ❑ Give you this Notice of our legal duties and privacy practices with respect to your protected health information
- ❑ Follow the terms of this Notice, as currently in effect.

This Notice is effective April 14, 2003, and applies to all of the medical records the City and our business associates maintain that have been provided to us through the Health Plans. If you are covered under one of the City's insured Health Plans, you may receive a similar notice from your Health Plan's insurance carrier.

How Your Personal Health Information May be Used and Disclosed
The City's Health Plans may disclose your protected health information to the claims payers, to business associates, and to certain employees of the City. These individuals may only use your protected health information for Health Plan payment and operations and certain other limited purposes, as described below. We may not and will not use your protected health information for any employment-related actions or decisions or in connection with any of the City's non-Health Plan benefits. Violations of these rules are subject to disciplinary action.

The City has certified that it will not use or disclose your protected health information other than as provided in this Notice or as required by law. Any business associates who are given your protected health information must agree to be bound by these restrictions and conditions concerning your protected health information.

Health Plan Payment: We will use and disclose your protected health information for Health Plan payment activities. For example, the Health FSA third party administrator ("TPA") will use protected health information to determine coverage eligibility, process reimbursement claims, and coordinate benefits with other health care programs or insurance carriers.

Health Care Operations: We may use and disclose your protected health information for Health Plan operations, such as monitoring the Carriers and TPAs to ensure that they are properly and accurately paying claims in accordance with the terms of the Health Plan documents, and that they are providing proper and timely services to you as required under the Health Plans. Designated employees of the City may receive, use, and disclose protected health information when assisting you with Health Plan problems or questions, such as eligibility, benefit coverage, and appeals. Protected health information also may be used when conducting quality assessment and improvement activities; underwriting and soliciting bids from potential Carriers or TPAs, establishing City and employee premium contributions and funding-related activities; determining need for disease management programs; submitting claims for stop-loss coverage; arranging medical or legal reviews or fraud detection programs; and managing costs. We may also share your protected health information with business associates who assist us in monitoring Health Plan costs, utilization, plan design, Health Plan disputes, and similar Health Plan payment and operations. Our auditors, attorneys, and other business associates may use protected health information in assuring accurate and complete compliance with the Health Plans' terms.

As Required By Law or Judicial Order: We will disclose information about you when required to do so by federal, state or local law, including when required by court orders and subpoenas, or by the police or other authorized governmental organizations. For example, we may disclose protected health information when required by a domestic relations order, a child support order, or a court order involving a civil lawsuit or criminal prosecution. In most instances, this information will be provided by the Carrier or the TPA.

To Avert a Serious Threat to Health or Safety: We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of others. Any disclosure, however, would only be to someone able to help mitigate or prevent the threat to health or safety and only to the extent necessary to mitigate or prevent the problem.

Special Situations: Although unlikely, we may be required or permitted by HIPAA to use or disclosure protected health information in certain special situations, including, but not limited to, disclosures: (1) required to comply with workers' compensation requirements; (2) to assist law enforcement, such as to identify a missing person or witness; (3) to health oversight agencies, for example in the course of Medicare audits and compliance with other applicable laws; and (4) to report on public health risks, such as to report adverse reactions to medicines.

Disposal of Protected Health Information: Once we no longer need your protected health information we will either destroy it, return it, or if neither is feasible, we will store it securely and prohibit further uses and disclosures except to the extent use or disclosure is unavoidable.

Your Written Authorization to Release Information

In addition to the uses and disclosures of protected health information described in this Notice or as provided in HIPAA regulations, your protected health information will be used or disclosed only with your written permission. If you give us your written authorization to use or disclose your protected health information, you may revoke that permission, in writing, at any time, but not for any actions we have already taken. If you revoke your permission, you must be specific about which entity's permission is being revoked.

Your Rights Regarding Your Protected Health Information

Right to Inspect and Copy: You have the right to inspect and copy your protected health information that is held in the Health Plan's official file, with certain exceptions, such as you cannot be given access to psychotherapy notes or information prepared for litigation. If you request a copy of the information, you may be charged a fee for the related costs, such as copying and mailing. If your request to inspect or copy your protected health information has been denied, you will be notified in writing of your rights of appeal at that time.

Right to Amend: If you feel that protected health information held in the Health Plan's official file is incorrect or incomplete, you must submit a written request that the information be amended; you must support the basis for your request. We are not required to grant your request if we do not maintain or did not create the information, or if it is correct. We must respond to your request within 60 days, unless a written notice of a 30-day extension is provided.

Right to an Accounting of Disclosures: You have the right to request an accounting, or list, of certain uncommon disclosures of your protected health information. Your request for a list of disclosures must state the time period for which you are requesting the accounting, but your request may not cover a time period that is longer than six years and may not include the period before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronically). The first list you request within a 12-month period will be free. For additional lists, you may be charged for the costs of providing the list. Your request for an accounting of the disclosures of your protected health information must be responded to no later than 60 days after receipt of the request, unless a written notice of a 30-day extension is provided.

Right to Request Restrictions: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for Health Plan payment or operations. You also have the right to request a limit on the protected health information disclosed about you to someone who is involved in your care or the payment for your care, such as a family member or friend when you are incapacitated or unavailable. In your request for restrictions, you must indicate: (1) what information you want to limit; (2) whether you want to limit the use, disclosure, or both; and (3) to whom you want the limits to apply, for example, prohibit disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that communications with you regarding your protected health information be made in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Your request must specify how or where you wish to be contacted. Although we are not required to agree to your request, we will accommodate all requests we deem reasonable.

Use of Personal Representatives: Your personal representative may act on your behalf. For example, a parent is a personal representative of a dependent minor, and a person with your power of attorney or a court order may be your personal representative.

Changes To This Notice
We reserve the right to change this Notice and will distribute as required. We reserve the right to make the revised Notice effective for protected health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice on the Plan websites at **http://www.dallascityhall.com/human_resources/benefits_employees.html** and **www.cityofdallasbenefits.com**.

Complaints and Questions
If you have questions about your HIPAA privacy rights or if you believe your rights have been violated, you may contact the City or one of the Health Plan representatives listed below or you may file a complaint with the Department of Health and Human Services. You will not be penalized for filing a complaint.

Human Resources Department	Health Plan Representatives Contact Information	
ATTN: Benefits Division 1500 Marilla Street, Room 1D South Dallas, Texas 75201-6390 Phone: 1-888-752-9122 Fax: 1-888-202-5571	United Healthcare (UHC) EPO Plans (75/25/HRA & 70/30) Caremark (CVS) - Prescription Services United Healthcare (UHC) - Flexible Spending Accounts United Healthcare (UHC) - Dental PPO & EPO Plans United Healthcare (UHC) - Dental HMO Plan United Healthcare (UHC) - Vision Standard & Buy-up Plans OptumHealth EAP (Employee Assistance Program) Colonial Life - Voluntary Benefit Plans AFLAC - Voluntary Benefit Plans	800-736-1364 855-465-0023 877-311-7849 877-816-3596 800-232-0990 800-638-3120 800-586-6875 800-325-4368 800-992-3522

Special Enrollment Notice
If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for your other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or place for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days following the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact the Benefits Service Center at 1-888-752-9122.

Wellness Program Disclosure
If it is unreasonably difficult for you to achieve the standards for a reward under the wellness program due to a medical condition, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call the Benefits Service Center at 1-888-752-9122, and we will work with you to develop another way to qualify for the reward.

Children's Health Insurance Program Notice

Medicaid and the Children's Health Insurance Program (CHIP) Free Offer or Low-Cost Health Coverage to Children & Families

If you are eligible for health coverage from your employer but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for one of these programs, you can contact your state Medicaid or CHIP office, or dial **1-877-KIDS-NOW**. You may also go to **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it has been determined that your or your dependents qualify for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan—granted that you and your dependents are eligible but not already enrolled in your employer's plan. This is called a "special enrollment" opportunity. **You must request coverage within 60 days of being determined eligible for premium assistance.**

You may be eligible for payment assistance with your employer's health plan premiums. You should contact your state for information on eligibility:

Texas Residents: Go to **http://www.gethipptexas.com/** or call **1-800-440-0493**.

To see which states have implemented a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you may use the following resources:

U. S. Department of Labor
Employee Benefits Security Administration
Website: www.dol.gov/ebsa
Phone: 1-866-444-EBSA (3272)
OMB Control Number 1210-0137 (expires 9-30-2013)

U. S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Website: www.cms.hhs.gov
Phone: 1-877-267-2323, Ext. 61565

Voluntary Benefits: Colonial Life

Not Sponsored by the City of Dallas
(available on an individual basis)

- Short-Term Disability Insurance
- Critical Illness Insurance
- Hospital Confinement Indemnity Insurance
- Universal Life Insurance

The City of Dallas does not sponsor the Voluntary Benefits disclosed on the following page.

Take Advantage of What Colonial Life Has to Offer! 122981

You have the opportunity to apply for personal insurance products from Colonial Life! These benefits can enhance your current benefits portfolio and can be customized to fit your individual needs.

- ❑ Coverages are available for you and your family, with most products.
- ❑ You will enjoy the convenience of premium payment through payroll deductions
- ❑ You will have the ability to take most coverages with you if you change jobs or retire.

The following insurance plans will be offered during Open Enrollment:

Short-Term Disability Insurance helps offset the financial losses that result when you are unable to work due to a covered injury or sickness.

Critical Illness Insurance complements your major medical coverage by providing a lump-sum benefit that you can use to help pay the direct and indirect costs related to a covered critical illness, which can often be expensive and lengthy.

Hospital Confinement Indemnity Insurance helps you with the rising costs associated with a covered hospital confinement or eligible outpatient surgery.

Universal Life Insurance enables you to tailor coverage for your individual needs and helps provide financial security for your family members. This policy comes with a long-term care benefit rider.

A Colonial Life benefits counselor will explain how these benefits can help protect you and your family. Your insurance needs can be reviewed in just a few minutes. With Colonial Life, you can select benefits that help meet your individual needs.

Products have exclusions and limitations that may affect benefits payable. See the Outline of Coverage for complete details.

New hires may enroll in these Colonial Life products by following these steps:

- ❑ Gather any information you may need to enroll, such as dependents' names, birth dates, ages, Social Security numbers and addresses.
- ❑ Call the Benefits Service Center at 1-888-752-9122 to be transferred to a benefits counselor who will be able to answer your questions and enroll you in the coverage of your choice.

To make changes or apply for Colonial voluntary benefits, please see a Colonial Life benefits counselor who will be available onsite during Open Enrollment or call the Benefits Service Center at 1-888-752-9122; when calling during Open Enrollment, select call options 1, 2 and 1.

For questions regarding your existing Colonial Life coverage, contact the Colonial Life Policyholder Services Department at 1-800-325-4368 or visit the Colonial Life website at www.coloniallife.com.

Colonial Life & Accident Insurance Company
1200 Colonial Life Boulevard, Columbia, SC 29210
Policyholder Services: 1-800-325-4368
Website: www.coloniallife.com

Colonial Life
Making benefits count.

Voluntary Benefits: Aflac

Not Sponsored by the City of Dallas
(available on an individual basis)

- Cancer
- Accident

The City of Dallas does not sponsor the Voluntary Benefits disclosed on the following page.

122981

Aflac for City of Dallas employees

City of Dallas is making the following Aflac insurance policies available to its employees:

1

Accident

After an accident, you may have expenses you've never thought about before. Can your finances handle them? It's reassuring to know that an accident insurance policy can be there for you through the many stages of care, from the initial emergency treatment or hospitalization, to follow-up treatments or physical therapy. In addition, your regular bills, such as the mortgage or rent, car payments and utility bills, don't stop when you're laid up after an accident. Aflac benefits are paid directly to you (unless you choose otherwise), so you can use them to help with your normal bills as well.

2

Cancer

Chances are you know someone who's been affected, directly or indirectly, by cancer. You also know the toll it's taken on them—physically, emotionally, and financially. Aflac's cancer insurance policies pay a cash benefit upon initial diagnosis of a covered cancer, with a variety of other benefits payable throughout cancer treatment. You can use these cash benefits to help pay out-of-pocket medical expenses, the rent or mortgage, groceries, or utility bills—the choice is yours.

Aflac for City of Dallas Employees:

- Aflac pays you cash benefits, unless assigned, to use as you see fit.
- Aflac benefits can help with unexpected expenses.
- Aflac insurance policies belong to you.
- Aflac offers competitive rates.
- Aflac processes claims quickly—usually within four days.[1]
- Thanks to the Aflac Duck, nine out of ten people in the United States know the Aflac name.[2]

[1]Company statistics, December 31, 2011.
[2]Aflac2011 Year in Review.

For more information about policy benefits, limitations, and exclusions, please call your Aflac insurance agent/producer, Rosalind George, at 972.490.0109 or toll free 800.981.6537 or email rosalind_george@us.aflac.com.

This is a brief product overview only. Policies may not be available in all states. Benefits are determined by state and plan level selected.

Aflac®

We've got you under our wing.®

Coverage is underwritten by American Family Life Assurance Company of Columbus.
In New York, coverage is underwritten by American Family Life Assurance Company of New York.

Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

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VENDOR CONTACT LIST

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City of Dallas HR-Benefits Service Center	
City of Dallas Benefits Website Website Phone	 www.cityofdallasbenefits.com 1-888-752-9122
City of Dallas Website	http://www.dallascityhall.com/
Medical Plan	
United Healthcare (UHC) EPO and HRA Plans Membership Services EPO/HRA myNurseLine Website	 1-800-736-1364 1-800-586-6875 www.myuhc.com
Pharmacy Plan	
CVS/Caremark Website	1-855-465-0023 www.caremark.com
Vision Plan (UHC)	
Vision Services Website	1-800-638-3120 www.myuhcvision.com
Dental Plan (UHC)	
Dental HMO Dental PPO and EPO Website	1-800-232-0990 1-877-816-3596 www.myuhcdental.com
COBRA (UHC)	
Membership Services Website	1-866-747-0048 www.uhcservices.com
Life Insurance (Standard Life)	
Membership Services Website	1-877-474-4250 or 214-670-4181 www.standard.com
Employee Assistance Program (EAP): OptumHealth	
Membership Services Website Access Code	1-800-586-6875 www.liveandworkwell.com/public CityofDallas
Deferred Compensation	
401K and 457 Plans **(Fidelity)** Website	1-800-343-0860 www.mysavingsatwork.com/atwork.htm
Employee Retirement Fund	
Phone Website	214-580-7700/1-877-246-1791 www.dallaserf.org
Dallas Police and Fire Pension	
Phone Website	1-800-638-3861/214-638-3863 www.dpfp.org
Wellness (WellAware)	
WellAware Website	http://cod/HumanResources/WellAware/index.htm
Voluntary Benefits	
Colonial Life Membership Services Website **Aflac** Membership Services Website	 1-800-325-4368 www.coloniallife.com 972-480-0109/1-800-992-3522 www.aflac.com

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City of Dallas Publication No. 11-12:67
Additional copies may be obtained from:
The Benefits Service Center @ 1-888-752-9122

About this Guide

This 2013 Benefits and Enrollment Guide describes, in non-technical language, the essential features of the City of Dallas Health Benefits Plan (The Plan). This Guide has been prepared as a reference only. It is not an official Master Plan Document for the City of Dallas Health Benefits Plan, which includes dental, vision, life and voluntary benefits. The terms and conditions of coverage under The Plan are determined solely by the Master Plan Document as adopted by the City of Dallas City Council. If there is a difference between what you read in this Guide and what you read in the official Summary Plan Document (SPD), the official Master Plan Document will govern.

City of Dallas

Human Resources Department
Benefits Service Center | 1500 Marilla Street, Room 1DS | Dallas, TX 75201
1-888-752-9122 (ph) | 1-888-202-5571 (fax)

The Benefits Service Center is open Monday through Friday from 8:15 a.m. to 5:15 p.m.

122981

Summary Plan Description

City of Dallas
Choice

Effective: January 1, 2013
Group Number: 708872

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: (800) 846-4678;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, Utah 84130-0555; and
- Online assistance: **www.myuhc.com**.

City of Dallas is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- 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.

City of Dallas 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. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. City of Dallas is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the City of Dallas Health Plan works. If you have questions contact City of Dallas Benefits Service Center at 1-888-752-9122 or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can request printed copies of the SPD by contacting City of Dallas Benefit Service Center.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- City of Dallas is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

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 enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time or permanent part-time Participant who is scheduled to work at least 20 hours per week or a person who retires while covered under the Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, (including Domestic Partner), as defined in Section 14, *Glossary*;
- you or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian or a tax dependent grandchild;
- a child age 26 or over who is or becomes disabled and dependent upon you; and
- certain survivors (see Survivorship Coverage in Section 12, *When Coverage Ends*)

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the City of Dallas Benefit Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the City of Dallas Benefit Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and City of Dallas share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld -

and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of City of Dallas' cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and the City Council reserves the right to change contributions required by the Plan.

You can obtain current contribution rates by calling City of Dallas Benefit Service Center at 1-888-752-9122.

How to Enroll

To enroll, call City of Dallas Benefit Service Center at 1-888-752-9122 within 30 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 30 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1. Retirees who previously waived coverage cannot re-enroll.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact City of Dallas Benefit Service Center within 30 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once City of Dallas Benefit Service Center receives your properly completed enrollment, coverage will begin on your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first of the month following the date City of Dallas Benefit Service Center receives notice of your marriage, provided you notify City of Dallas Benefit Service Center within 30 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify City of Dallas Benefit Service Center within 30 days of the birth, adoption, or placement.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- registering a Domestic Partner;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact City of Dallas Benefit Service Center within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact City of Dallas Benefit Service Center within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact City of Dallas Benefit Service Center within 30 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status 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 above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical 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.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Out-of-Pocket Maximum;
- Coinsurance.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Network Physician or health care professional you prefer each time you need to receive Covered Health Services.

You are eligible for Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. Except as specifically described within the SPD benefits are not available for services provided by a non-Network provider.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services and Covered Health Services received at an Urgent Care Center outside your geographic area are always paid as Network Benefits.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a 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. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of City of Dallas or UnitedHealthcare.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will not be paid.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

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

Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition in Section 14, *Glossary*. For certain Covered Health Services, the Plan will not pay these expenses until you have met your Annual Deductible. City of Dallas has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a Network provider. If you do not show your ID card, a Network provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

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

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

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. Copays do not count toward the Out-of-Pocket-Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance - Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 70%, you are responsible for paying the other 30%. This 30% is your Coinsurance.

Out-of-Pocket Maximum

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

The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

Plan Features	Applies to the Out-of-Pocket Maximum?
Copays	No
Payments toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for non-Covered Health Services	No

SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:
- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact 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 you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components and notification requirements are subject to change without notice. As of the publication of this SPD, the Personal Health Support 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 a certain chronic or complex condition, 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 toll-free number on your ID card.

Requirements for Notifying Personal Health Support

In most cases, Network providers are responsible for notifying Personal Health Support before they provide these services to you. However, you are responsible for notifying the Personal Health Support staff prior to receiving a service for:

- dental services - accident only;
- obesity surgery; and
- transplantation services.
- Cancer Resource Services
- Kidney Resouce Services
- Reconstructive Procedures

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB).*

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of the coinsurance percentage or Copayment amount that applies when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network
Copays	
■ Emergency Health Services	$100
Annual Deductible[2]	
■ Individual	$3,000
■ Family (not to exceed $3,000 per Covered Person)	$9,000
Annual Out-of-Pocket Maximum[2]	
■ Individual	$7,500
■ Family (not to exceed $7,500 per Covered Person)	$15,000
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited

[1]In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.

[2]Copays do not apply toward the Annual Deductible or Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details.*

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Acupuncture Services	70% after you meet the Annual Deductible
Ambulance Services ■ Emergency Ambulance	70% after you meet the Annual Deductible
Cancer Resource Services (CRS) ■ Hospital Inpatient Stay	70% after you meet the Annual Deductible
Congenital Heart Disease (CHD) Surgeries	70% after you meet the Annual Deductible
Dental Services - Accident Only	70% after you meet the Annual Deductible
Diabetes Services ■ Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 15, *Prescription Drugs.*
Durable Medical Equipment (DME)	70% after you meet the Annual Deductible
Emergency Health Services - Outpatient Emergency services received at a non-Network Hospital are covered at the Network level. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	*Emergency Room Facility* 100% after you pay a $100 Copay *All other Services Required in Emergency Room* 70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Extreme Vision	70% after you meet the Annual Deductible
Hearing Aids	70% after you meet the Annual Deductible
Home Health Care Up to 30 visits per calendar year	70% after you meet the Annual Deductible
Hospice Care	70% after you meet the Annual Deductible
Hospital - Inpatient Stay	70% after you meet the Annual Deductible
Kidney Resource Services (KRS) (These Benefits are for Covered Health Services provided through KRS only)	70% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics – Outpatient	70% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	70% after you meet the Annual Deductible
Mental Health Services ■ Hospital - Inpatient Stay ■ Physician's Office Services	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Neonatal Resource Services (NRS) (These Benefits are for Covered Health Services provided through NRS only)	70% after you meet the Annual Deductible
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders ■ Hospital - Inpatient Stay ■ Physician's Office Services	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Nutritional Counseling	70% after you meet the Annual Deductible
Obesity Surgery ■ Physician's Office Services ■ Physician Fees for Surgical and Medical Services ■ Hospital - Inpatient Stay See Section 6, *Additional Coverage Details* for limits	70% after you meet the Annual Deductible
Ostomy Supplies	70% after you meet the Annual Deductible
Pharmaceutical Products – Outpatient See Section 6, *Additional Coverage Details*	70% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	70% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	70% after you meet the Annual Deductible
Pregnancy - Maternity Services ■ Physician's Office Services ■ Hospital - Inpatient Stay ■ Physician Fees for Surgical and Medical Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	100% 70% after you meet the Annual Deductible 70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Preventive Care Services ■ Breast Pumps ■ Physician Office Services ■ Lab, X-ray or Other Preventive Tests	100% Deductible does not apply 100% Deductible does not apply 100% Deductible does not apply
Private Duty Nursing - Outpatient Up to 30 visits per calendar year	70% after you meet the Annual Deductible
Prosthetic Devices	70% after you meet the Annual Deductible
Reconstructive Procedures ■ Physician's Office Services ■ Hospital - Inpatient Stay ■ Physician Fees for Surgical and Medical Services ■ Prosthetic Devices ■ Surgery - Outpatient	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible 70% after you meet the Annual Deductible 70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits	70% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	70% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 120 days per calendar year	70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Substance Use Disorder Services ■ Hospital - Inpatient Stay ■ Physician's Office Services	 70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Surgery – Outpatient	70% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	70% after you meet the Annual Deductible
Therapeutic Treatments – Outpatient	70% after you meet the Annual Deductible
Transplantation Services (If services rendered by a Designated Facility)	70% after you meet the Annual Deductible
Travel and Lodging (If services rendered by a Designated Facility)	For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment or transplant procedures
Urgent Care Center Services	70% after you meet the Annual Deductible
Wigs Up to $300 per calendar year	70% after you meet the Annual Deductible

[1]In general, your Network provider must notify Personal Health Support, as described in Section 4, before you receive certain Covered Health Services. There are some Network Benefits, however, for which you are responsible for notifying Personal Health Support. See Section 6, *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services -Sickness and Injury*, *Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Lab, X-Ray and Diagnostics - Outpatient*, and *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient.*

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call Personal Health Support.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy when both of the following are true:

- another method of pain management has failed; and
- the service is performed by an MD in the provider's office.

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 14, *Glossary* for the definition of Emergency.

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

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or

- visit www.urncrs.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits for Network services 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.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Facility.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include 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
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, 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.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Dental Services - Accident Only

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

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from 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 occurs 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 Injury and if extenuating circumstances exist due to the severity of the Injury.)

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:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

- 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; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Please remember that you should notify Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment.

Diabetes Services

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

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.
Diabetic Self-Management Items	Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 15, *Prescription Drugs.*

Durable Medical Equipment (DME)

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

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in 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. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- burn garments;
- filters for sleep apnea machines;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, including 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 orthotic devices and 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 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. Benefits are limited as stated below.

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

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

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

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including 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 anytime and are not subject to the three year timeline for replacement.

Emergency Health Services - Outpatient

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

If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, no Benefits will be paid.

Extreme Vision

The Plan's pays for Benefits for the following:

- necessary contact lenses or eyeglasses to correct vision problems following cataract surgery; and

- evaluation, fitting cost and purchase cost of contact lenses if there is a diagnosis of Karatoconus.

Benefits are limited to once every 12 months.

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 do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons 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.

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 in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, intermittent schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

Personal Health Support 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" simply because there is not an available caregiver.

Benefits are limited to 30 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital 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.*

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

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined in Section 14, *Glossary.*

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

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by Personal Health Support; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, 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.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include, but are not limited to:

- lab and radiology/x-ray; and
- mammography.

Benefits under this section include:

- 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*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services 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:

- 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.*

Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services; and
- crisis intervention.

Benefits include the following ser vices provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

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. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. 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 Covered Person and is not mandatory.

Please remember you should notify UnitedHealthcare, the MH/SUD Administrator, to receive these Benefits in advance of any treatment. Please call the phone number that appears on your ID card.

Neonatal Resource Services (NRS)

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated Facilities participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. Designated Facility is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, the Network provider must notify NRS or Personal Health Support if the newborn's NICU stay is longer than the mother's hospital stay.

You or a covered Dependent may also:

- call Personal Health Support; or
- call NRS toll-free at (888) 936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, 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.

Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders

The Plan pays Benefits for psychiatric services for Autism Spectrum 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 or property and impairment in daily functioning.

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

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provided-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care with regard to services for Autism Spectrum Disorder. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Please remember you should notify UnitedHealthcare, the MH/SUD Administrator, to receive the Benefits for Autism Spectrum Disorder in advance of any treatment. Please call phone number that appears on your ID card.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional for Covered Persons with diabetes that require a special diet.

Obesity Surgery

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician.

Morbid obesity means morbid or clinically severe obesity correlated with a Body Mass Index (BMI) of 40 kg/m2 or with being 100 pounds over ideal body weight and 30% over ideal body weight with underlying medical conditions

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Surgery is limited to a lifetime benefit of $5,000. There is no calendar year limit for non-surgical treatment.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Physician Fees for Surgical and Medical Services

The Plan pays 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 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 allergy injections and hearing exams in case of Injury or Sickness.

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

Pregnancy - Maternity Services

Employee and Dependent Spouse Only

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for postnatal care, delivery, and any related complications.

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 Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

For Dependent Children Only

Pregnancy Benefits for Dependent children are limited to Covered Health Services for Complications of Pregnancy. For a complete definition of Complications of Pregnancy, see Section 14, *Glossary.*

Benefits are payable for Covered Health Services for the treatment of Complications of Pregnancy given to a Dependent child while covered under this Plan.

Benefits for Complications of Pregnancy are paid in the same way as benefits are paid for Sickness.

Benefits for Complications of Pregnancy which result in the delivery of a child are payable for at least:

- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery; and
- 96 hours of inpatient care for the mother and newborn child following a cesarean section.

The following are not considered Complications of Pregnancy:

- false labor;
- occasional spotting;
- rest prescribed by a Physician;

- morning sickness; and
- other conditions that may be connected with a difficult pregnancy but are not a classifiably distinct complication.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

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

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

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Benefits are limited to 30 visits per Covered Person per calendar year.

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 provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

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 would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. 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.

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. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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 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 the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the

appearance of a body part. Cosmetic procedures are excluded from coverage. 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 14, *Glossary.*

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

Please remember that you should notify Personal Health Support five business days before undergoing a Reconstructive Procedure. When you provide notification, Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Benefits are limited to:

- 20 visits per calendar year for physical therapy;
- 20 visits per calendar year for occupational therapy;
- 20 visits per calendar year for speech therapy;
- 20 visits per calendar year for Manipulative Treatment.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays 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 those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

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

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 arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

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, including anesthesiologists, consulting Physicians, pathologists and radiologists, are described in this section under *Physician Fees for Surgical and Medical Services.*

UnitedHealthcare 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
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

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

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons 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 14, *Glossary.*

Benefits are limited to 120 days per calendar year.

Substance Use Disorder Services

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

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management;
- crisis intervention; and
- detoxification (sub-acute/non-medical).

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

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. The Substance Use Disorder Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use 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 Covered Person and is not mandatory.

Please remember you should notify UnitedHealthcare, the MH/SUD Administrator, to receive these Benefits in advance of any treatment. Please call phone number that appears on your ID card.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

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

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

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

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 arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *U.S. Food and Drug Administration (FDA)*-approved TMJ implants only when all other treatment has failed.

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.

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 healthcare professionals when:

- education is 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.

Benefits under this section include:

- 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.*

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network provider and received at a Designated Facility. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. 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 that are provided by a Network provider at a Network Hospital. You are not required to notify United Resource Networks or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

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.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the telephone number on your ID card for information about these guidelines.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Facility.

Travel and Lodging

United Resource Networks or Personal Health Support will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD);
- transplantation services; and
- cancer-related treatments.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment, the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $75 per day for the patient or up to $100 per day for the patient plus one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility (for CRS and transplantation) or the CHD facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

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.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *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.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis regardless of the reason of hair loss.

Benefits are limited to $300 per calendar year.

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

City of Dallas believes in giving you the tools you need to be an educated health care consumer. To that end, City of Dallas has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
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 own health. UnitedHealthcare and City of Dallas 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 text.

Consumer Solutions and Self-Service Tools

Employee Assistance Program (EAP)

UnitedHealthcare offers free counseling and referral services nationwide through the Employee Assistance Program (EAP). Using a solution focused approach to care, they tailor their interventions to meet your individual needs. The program can help you and your immediate family members cope with issues such as:

- family or relationship problems;
- parenting difficulties;
- work-related problems;
- financial and legal issues;
- substance use or abuse;
- grief and loss; and
- anxiety.

Call the toll-free phone number on the back of your ID card to speak to a specially trained, master's-level specialist who will recommend the right resources for your specific life

concern. Services are available any time, 24 hours a day, seven days per week and are strictly confidential in accordance with state and federal laws.

Health Assessment

You are invited to learn more about your health and wellness at **www.myuhc.com** 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.

To find the health assessment, log in to **www.myuhc.com**. 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 the number on the back of your ID card.

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;
- smoking 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 – City of Dallas' way of helping you meet your health and wellness goals.

NurseLine℠

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. 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 City of Dallas 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 in Spanish.

NurseLine is available to you at no cost.

Note: If you have a medical emergency, call 911 instead of calling NurseLine.

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. 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** 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 logging onto **www.myuhc.com**.

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 the number on the back of your ID card.

UnitedHealth Premium℠ Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium 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 and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- 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;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;

- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** 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 Physician.

Disease and Condition Management Services

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 even 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 and 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 the number on the back of your ID card.

HealtheNotes℠

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

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

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

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

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. 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 the toll-free number on the back of your ID card.

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.

SECTION 8 - 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, *Additional Coverage Details.*

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights.* Limits may also 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, *Plan Highlights.* Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

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

Alternative Treatments

1. acupressure
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. Rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details.*

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

   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. Examples include treatment

of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

   - extractions (including 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 accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details.*

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

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details.*

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

   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 for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details.*

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

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, *Additional Coverage Details*:

   Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter.

3. cranial banding;

4. the following items are excluded, even if prescribed by a Physician:

   - blood pressure cuff/monitor;
   - enuresis alarm;

- non-wearable external defibrillator;
- trusses;
- ultrasonic nebulizers;

5. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

6. the replacement of lost or stolen prosthetic devices;

7. 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, *Additional Coverage Details* ; and

8. oral appliances for snoring.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the prescription portion of the Plan, which is administered by Caremark. Please visit **www.caremark.com** or call the number on your ID Card for more information.

1. Prescription Drugs for outpatient use that are filled by a prescription order or refill;

2. self-injectable medications (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);

3. growth hormone therapy;

4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and

5. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *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.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

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

2. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet;
   - 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;

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. treatment of flat feet;

4. shoe inserts;

5. arch supports;

6. shoes (standard or custom), lifts and wedges; and

7. shoe orthotics.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

   - elastic stockings, ace bandages, diabetic strips, and syringes; and
   - urinary catheters.

   This exclusion does not apply to:

   - ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*; or
   - diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, Additional Coverage Details.

2. 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; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details.*

Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders* [2]and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details.*

1. services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that , in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:

3. not consistent with generally accepted standards of medical practice for the treatment of such conditions;

4. not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;

5. not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or

6. not clinically appropriate for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

7. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

8. Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;

9. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal);

10. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;

11. tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act;

12. learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

13. mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

14. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction; and

15. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

1. nutritional or cosmetic therapy using high dose 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*, and except as defined under *Nutritional Counseling* in Section 6, *Additional Coverage Details*;

3. food of any kind. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are the only source of nutrition and even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - foods to control weight, treat obesity (including 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 and electrolyte supplements; and

4. 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. supplies, equipment and similar incidentals for personal comfort. Examples include:

   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - electric scooters;
   - 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; and
   - home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and

- replacement of an existing intact 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, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;

4. treatment of benign gynecomastia (abnormal breast enlargement in males).

Preexisting Conditions

1. Benefits for the treatment of a Preexisting Condition are excluded unless you have had Continuous Creditable Coverage for 12 months. Preexisting Condition is defined in Section 14, *Glossary.*

   This exclusion does not apply to Covered Persons under age 25.

Procedures and Treatments

1. biofeedback;

2. 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);

3. rehabilitation services and Manipulative 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;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

8. psychosurgery (lobotomy);

9. treatment of tobacco dependency;

10. chelation therapy, except to treat heavy metal poisoning;

11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, such as asthma or allergies;

12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

13. sex transformation operations;

14. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*;

15. medical and surgical treatment of hyperhidrosis (excessive sweating);

16. the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations;

17. upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor or cancer. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment, except as treatment of obstructive sleep apnea; and

18. breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

   - prior to ordering the service; or
   - after the service is received.

   This exclusion does not apply to mammography testing.

Reproduction

1. health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment

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

2. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);

3. surrogate parenting, donor eggs, donor sperm and host uterus;

4. the reversal of voluntary sterilization;

5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

6. prenatal, labor and delivery coverage for enrolled Dependent children except those that have Complications of Pregnancy as defined in Section 14, *Glossary*;

7. fetal reduction surgery;

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

   This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

9. contraceptive supplies and services (certain contraceptives are covered at 100%, not subject to the Annual Deductible, per Health Care Reform. Contact UnitedHealthcare for additional information);

10. services provided by a doula (labor aide); and

11. parenting or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);

3. transplants that are not performed at a Designated Facility (this exclusion does not apply to cornea transplants); and

4. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary;*

3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

4. Private Duty Nursing received on an inpatient basis;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in Section 6, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants; and

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;

2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

3. purchase cost and associated fitting charges for eyeglasses or contact lenses;

4. bone anchored hearing aids except when either of the following applies:

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

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

5. eye exercise or vision therapy; and

6. 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; or

- 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; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

   - that do not meet the definition of a Covered Health Service in Section 14, *Glossary*;
   - that 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 Covered Persons 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 which 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 Benefit Plan; or
   - that exceed Eligible Expenses or any specified limitation in this SPD;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; and

8. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - required solely for purposes of education, sports or camp, insurance, marriage or adoption; or as a result of incarceration;
   - conducted for purposes of medical research;
   - related to judicial or administrative proceedings or orders; or
   - required to obtain or maintain a license of any type.

9. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

SECTION 9 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

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 the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and 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 Benefits

If you receive a bill for Covered Health Services from a non-Network provider as a result of an Emergency, 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 address on the back of your ID card.

Prescription Drug Benefit Claims

Prescription coverage is available through Caremark. For information on submitting your outpatient prescription drug claims, call the toll-free number on your ID Card or visit **www.caremark.com**.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting City of Dallas Benefit Service Center. 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 patient's name, age and relationship to the Participant;
- the number as shown on your 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 carrier(s).

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

The above information should be filed with us at the address on your ID card. After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the 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 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, your provider, and not to a third party, even if your provider has assigned Benefits to that third party.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. 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 paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Claims
All claim forms must be submitted within 90 days 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 City of Dallas. This 90 day 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 the number on your ID card 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, post-service claim or a rescission of coverage determination as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the 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 request.

You or your enrolled Dependent may send a written request for an appeal to:

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

Customer Service: 800-736-1364

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card 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;
- post-service claim; or
- concurrent claim.

Review of an 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 will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from City of Dallas within 60 days from receipt of the first level appeal determination. City of Dallas must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. City of Dallas will review all claims in accordance with the rules established by the U.S. Department of Labor. City of Dallas's decision will be final.

Federal External Review Program

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

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

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or

- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card 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 received City of Dallas' decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; 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; and
- a decision by the IRO.

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

- is or was covered under the 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 a notification in writing to you. 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.

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 of receipt of the notice additional information that the IRO will 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.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making City of Dallas' determination. The documents include:

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

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by City of Dallas. 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 they request 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 City of Dallas' determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. 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.

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 individual or would jeopardize the individual'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 timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual'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 individual received emergency services, but has not been discharged from a facility.

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

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

After UnitedHealthcare completes 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 City of Dallas. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and

- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
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** after receiving an extension notice*
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
City of Dallas must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal**

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

**City of Dallas may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
City of Dallas must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may be entitled to a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

**City of Dallas may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

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 timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against City of Dallas or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against City of Dallas or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against City of Dallas or the Claims Administrator.

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

SECTION 10 - 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 any one of the following:

- another employer sponsored health benefits 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 auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

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 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** or call the toll-free number on your ID card 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:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

- 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 pays benefits first is the one that has been in effect the longest. 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 without specifying that one party 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;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; Only expenses normally paid by the Plan will be paid under COB; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

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 Participant 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.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the primary plan's allowable expense.
- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.

- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense When This Plan is Secondary

When this Plan is secondary, the allowable expense is the primary plan's Network rate. 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.

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

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

- employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary

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 are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Right to Receive and Release Needed Information

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

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

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 UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If City of Dallas pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to City of Dallas if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment City of Dallas made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

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

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

SECTION 11 - 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 you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent 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 provides an advancement of benefits to you or your Dependent during the time period of the Deductible and/or meeting the 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 it has advanced 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 you 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 considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a

Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

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

Right to Reimbursement

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

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity who caused the Sickness, Injury or damages;
- City of Dallas in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers' compensation coverage; or
  - any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
- the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- 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) or judgment, 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.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - complying with the terms of this section;
  - providing any relevant information requested;
  - signing and/or delivering documents at its request;
  - notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - responding 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 before releasing any party from liability or payment of medical expenses.
- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- you may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- 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 provided for a Sickness or Injury caused by a third party.
- the Plan's rights will not be reduced due to your own negligence.
- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including 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 apply to the parents, guardian, or other representative of a Dependent child 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.
- 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.

- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- if a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Subrogation – 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. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

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

When your coverage ends, City of Dallas 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 coverage ended, even if the underlying medical condition occurred before your coverage ended.

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

- the last day of the month your employment with the Company ends;
- the date the Plan ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you are no longer eligible;
- the last day of the month UnitedHealthcare receives written notice from City of Dallas to end your coverage, or the date requested in the notice, if later; or
- the last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

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

- the date your coverage ends;
- the last day of the month you stop making the required contributions;
- the last day of the month UnitedHealthcare receives written notice from City of Dallas to end your coverage, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

The Plan will provide written notice to you that your coverage has ended if any of the following occur:

- you permit an unauthorized person to use your ID card or you use another person's ID card;
- you knowingly give UnitedHealthcare false material information including, but not limited to, false information relating to another person's eligibility or status as a Dependent;

- you commit an act of physical or verbal abuse that imposes a threat to City of Dallas' staff, UnitedHealthcare's staff, a provider or another Covered Person; or
- you violate any terms of the Plan.

Note: City of Dallas has the right to demand that you pay back Benefits City of Dallas paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to City of Dallas proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon City of Dallas' request, that the child continues to meet these conditions.

The proof might include medical examinations at City of Dallas' expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under COBRA.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if City of Dallas is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

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

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

- a Participant;

- a Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines 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 considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
City of Dallas files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months 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 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.

[2]This is a qualifying event for any Retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Participant's death if the Participant dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. 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 Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

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

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction.*

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation 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 the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

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

Once you have notified the Plan Administrator, 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 City of Dallas Benefit Service Center 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 the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA.* The contents of the notice must be such that the Plan Administrator 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 Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

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

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- 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 Participant 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 Participant and the Participant'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, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

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

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

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant'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 the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

Survivorship Coverage

If the employee dies while covered under the Plan, the surviving spouse and any eligible dependents may continue coverage under the Plan until the end of the month following a period of 90 days subsequent to the employee's death. After the initial 90 days following the employee's date of death, coverage is then available to the surviving spouse and any eligible dependents through the COBRA provision, except for a surviving spouse of an active uniformed officer killed in the line of duty. A surviving spouse of an active uniformed officer may continue coverage on the existing plan at active rates. If a surviving spouse remarries, coverage under the Plan will terminate.

A surviving spouse who is covered under a retiree Plan may continue coverage as long as he/she is eligible for pension benefits. Any dependents acquired through the remarriage of a retired employee's surviving spouse will not be eligible for coverage under the Plan.

A surviving spouse and eligible dependents of a retired employee may remain in the Plan after the death of the retired employee:

- If the person was covered as a dependent spouse of the deceased retired employee at the time of the retired employee's death and is eligible to receive pension benefits;
- If carried as a dependent child, the person remains a dependent of the surviving spouse, but only if the spouse is receiving monthly survivor's benefits from one of the retirement funds.

Coverage for all surviving dependents ceases if coverage for the surviving spouse stops because of death, termination of monthly benefits, or any other reason.

A retired employee, or a surviving spouse or dependent who is eligible for Medicare participation by reason of age or disability or any other reason, must enroll and remain enrolled in Medicare Parts A and B in order to retain eligibility in the Plan.

The City will pay the Medicare Part A monthly premium on behalf of the retired employees and spouses of retired employees who are not otherwise qualified for Medicare. Retired employees are responsible for notifying the City, otherwise, they will be responsible for payment of the Medicare Part A premium. The retired employee and retired employee's spouse are responsible for payment of all Medicare Part B premiums.

If a retired employee is enrolled in this Plan on January 1, and elects to discontinue coverage in this Plan, the retired employee will not be eligible to enroll at a later date or in a subsequent plan

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and City of Dallas;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

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 medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

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 City of Dallas

In order to make choices about your health care coverage and treatment, City of Dallas believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- City of Dallas and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

City of Dallas and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. City of Dallas and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. City of Dallas and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between City of Dallas, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not City of Dallas' agents or employees, nor are they agents or employees of UnitedHealthcare. City of Dallas and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

City of Dallas and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, City of Dallas and UnitedHealthcare arranges for health care providers to participate in a Network and pay Benefits. 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. They are not City of Dallas' employees nor are they employees of UnitedHealthcare. City of Dallas and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. City of Dallas and UnitedHealthcare are not liable for any act or omission of any provider.

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

City of Dallas as the Plan Administrator is solely responsible for:

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

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;

- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

City of Dallas and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

City of Dallas and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

Information and Records

City of Dallas and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. City of Dallas and UnitedHealthcare may request additional information from you to decide your claim for Benefits. City of Dallas and UnitedHealthcare will keep this information confidential. City of Dallas and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

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

City of Dallas and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan,

for appropriate medical review or quality assessment, or as City of Dallas is required to do by law or regulation. During and after the term of the Plan, City of Dallas and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements City of Dallas 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, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, City of Dallas and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

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

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but City of Dallas recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

City of Dallas and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. City of Dallas and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD 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 SPD, but it does not describe the Benefits provided by the Plan.

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

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 Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount of Eligible Expenses you must pay for Covered Health Services in a calendar year before you are eligible to begin receiving Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights.*

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

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

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).

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

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

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as UnitedHealthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

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 patient is not allowed to choose which treatment will be received.

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.*

Company – City of Dallas.

Complications of Pregnancy – a condition suffered by a Dependent child that requires medical treatment before or after Pregnancy ends.

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

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects 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 to certain employees and their dependents whose group health insurance has been terminated.

Continuous Creditable Coverage – health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- a group health plan;
- health insurance coverage;
- Medicare;
- Medicaid;
- medical and dental care for members and certain former members of the uniformed services, and for their dependents;
- a medical care program of the Indian Health Services Program or a tribal organization;
- a state health benefits risk pool;
- The Federal Employees Health Benefits Program;
- The State Children's Health Insurance Program (S-CHIP);
- health plans established and maintained by foreign governments or political subdivisions and by the U.S. government;
- any public health benefit program provided by a state, county, or other political subdivision of a state; or
- a health benefit plan under the Peace Corps Act.

If you or your eligible Dependents were covered by any of the above plans before first becoming covered by this Plan, you should have received a Certificate of Creditable Coverage when that plan's coverage ended.

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 Claims Administrator. 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 function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which City of Dallas determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms;
- consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below;

- not provided for the convenience of the Covered Person, Physician, facility or any other person;
- included in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community; and
- "prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

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, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient 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.

Deductible – see Annual Deductible.

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

Designated Facility – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specific conditions.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between a Participant and one other person of the same sex. Both persons must:

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent and have furnished documents to support at least two of the following conditions of such financial interdependence:
  - they have a single dedicated relationship of at least 6 months duration;
  - they have joint ownership of a residence; or
  - they have at least two of the following:
    - a joint ownership of an automobile;
    - a joint checking, bank or investment account;
    - a joint credit account;
    - a lease for a residence identifying both partners as tenants; or
    - a will and/or life insurance policies which designate the other as primary beneficiary.

The Participant and Domestic Partner must jointly sign an affidavit of domestic partnership provided by City of Dallas Benefit Service Center upon your request.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – charges for Covered Health Services that are provided while the Plan is in effect, determined as follows:

For:	Eligible Expenses are Based On:
Network Providers	contracted rates with that provider
Non-Network Providers	If you receive Covered Health Services from a non-Network provider in an Emergency, Eligible Expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or Substance Use Disorders 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.

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

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – City of Dallas.

EOB – see Explanation of Benefits (EOB).

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

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

Exceptions:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and City of Dallas may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UnitedHealthcare and City of Dallas must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

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

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, 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 or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

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

Inpatient Rehabilitation Facility – a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides physical therapy, occupational therapy and/or speech therapy on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

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

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by City of Dallas. The KRS program provides:

- specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

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

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

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

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

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the organization or individual designated by City of Dallas who provides or arranges Mental Health and Substance Use Disorder Services under the Plan. The current Administrator is UnitedHealthcare

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions.*

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by City of Dallas. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator'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 some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network provider. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Open Enrollment – the period of time, determined by City of Dallas, during which eligible Participants may enroll themselves and their Dependents under the Plan. City of Dallas determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

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

Participant – a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction.* A Participant must live and/or work in the United States.

Personal Health Support – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

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 – 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.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that 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 City of Dallas Medical Plan.

Plan Administrator – City of Dallas or its designee.

Plan Sponsor – City of Dallas.

Preexisting Condition – any Sickness or Injury that is identified by the Plan Administrator as having been diagnosed or treated, or for which Prescription Drugs were prescribed or taken within the six months before coverage under this Plan begins (or the first day of any waiting period, if earlier). A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.

If you have Continuous Creditable Coverage, you or your Dependent will be eligible to receive Plan Benefits for a Preexisting Condition. Continuous Creditable Coverage is defined in this section.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with Pregnancy.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

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 surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

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

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the 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.

Retired Employee – an Employee who retires while covered under the Plan.

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

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider.

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

Skilled Care – skilled nursing, teaching, and 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 patient;
- 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.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Specialist Physician.

Spouse – an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded.

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, 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 Covered Person with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members 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 doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program – a program that identifies network Physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the 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 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**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and City of Dallas may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and City of Dallas must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.
- UnitedHealthcare and City of Dallas may, in their discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that UnitedHealthcare and City of Dallas do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies must be available in published peer-reviewed medical literature that would allow UnitedHealthcare and City of Dallas to conclude that the service is promising but unproven.
  - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare and City of Dallas's discretion. Other apparently similar promising but unproven services may not qualify.

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 minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

UnitedHealthcare Services, Inc.

185 Asylum Street
Hartford, CT 06103-3408

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

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Services, Inc.. The named fiduciary of Plan is City of Dallas, the Plan Sponsor.

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

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

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

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

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

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

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 Summary Plan Description (see Section 5, *Plan Highlights*) 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 Dependents as defined in the Summary Plan Description in Section 14, *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 the number on the back of your ID card.

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 ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your 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 the toll-free phone number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description 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 people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

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 insurance plan for Covered Health Services described in the Summary Plan Description 5, *Plan Highlights*) 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 your health 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 receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *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 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps facilities and clinics online based on location, compare 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 even work with a single 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 via phone (toll-free) by calling 1-866-774-4626.

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 1-877-801-3507 (toll-free).

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Summary Plan Description

City of Dallas
HRA Choice

Effective: January 1, 2013
Group Number: 708872

122981

122981

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: (800) 846-4678;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, Utah 84130-0555; and
- Online assistance: **www.myuhc.com**.

City of Dallas is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- 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.

City of Dallas 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. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. City of Dallas is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the City of Dallas Health Plan works. If you have questions contact City of Dallas Benefits Service Center or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can request printed copies of the SPD by contacting City of Dallas Benefit Service Center.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- City of Dallas is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

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 enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time or permanent part-time Participant who is scheduled to work at least 20 hours per week or a person who retires while covered under the Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 14, *Glossary*;
- you or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian or a tax dependent grandchild;
- a child age 26 or over who is or becomes disabled and dependent upon you.
- Certain survivors (see Survivorship Coverage in Section 12)

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the City of Dallas Benefit Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the City of Dallas Benefit Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and City of Dallas share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld -

and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their eligible Dependents. Therefore, the value of City of Dallas' cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and the City Council reserves the right to change contributions required by the Plan.

You can obtain current contribution rates by calling City of Dallas Benefit Service Center.

How to Enroll

To enroll, call City of Dallas Benefit Service Center within 30 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 30 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1. Retirees who previously waived coverage cannot re-enroll.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact City of Dallas Benefit Service Center within 30 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once City of Dallas Benefit Service Center receives your properly completed enrollment, coverage will begin on your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first of the month following the date City of Dallas Benefit Service Center receives notice of your marriage, provided you notify City of Dallas Benefit Service Center within 30 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify City of Dallas Benefit Service Center within 30 days of the birth, adoption, or placement.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- registering a Domestic Partner;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact City of Dallas Benefit Service Center within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact City of Dallas Benefit Service Center within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact City of Dallas Benefit Service Center within 30 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status 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 above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical 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.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Out-of-Pocket Maximum;
- Coinsurance.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Network Physician or health care professional you prefer each time you need to receive Covered Health Services.

You are eligible for Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. Except as specifically described within the SPD benefits are not available for services provided by a non-Network provider.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services and Covered Health Services received at an Urgent Care Center outside your geographic area are always paid as Network Benefits.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a 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. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of City of Dallas or UnitedHealthcare.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will not be paid.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

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

Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition in Section 14, *Glossary*. For certain Covered Health Services, the Plan will not pay these expenses until you have met your Annual Deductible. City of Dallas has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a Network provider. If you do not show your ID card, a Network provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services Expenses before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year. The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drugs*.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

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. Copays do not count toward the Out-of-Pocket-Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance - Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 70%, you are responsible for paying the other 30%. This 30% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year. The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drugs.*

The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

Plan Features	Applies to the Out-of-Pocket Maximum?
Copays	No
Payments toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for non-Covered Health Services	No

Lifetime Maximum Benefit

The Lifetime Maximum Benefit is the most the Plan will pay for Benefits during the entire period you are enrolled under this Plan offered by City of Dallas.

SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact 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 you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components and notification requirements are subject to change without notice. As of the publication of this SPD, the Personal Health Support 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 a certain chronic or complex condition, 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 toll-free number on your ID card.]

Requirements for Notifying Personal Health Support

In most cases, Network providers are responsible for notifying Personal Health Support before they provide these services to you. However, you are responsible for notifying the Personal Health Support staff prior to receiving a service for:

- dental services - accident only;
- obesity surgery; and
- transplantation services.

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB).*

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of the coinsurance percentage that applies when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network
Annual Deductible[2]	
■ Individual	$2,500
■ Family (not to exceed $2,500per Covered Person)	$5,000
Annual Out-of-Pocket Maximum[2]	
■ Individual	$6,000
■ Family (not to exceed $6,000 per Covered Person)	$12,000
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details.*

Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:
	Network
Acupuncture Services	75% after you meet the Annual Deductible
Ambulance Services ■ Emergency Ambulance	75% after you meet the Annual Deductible
Cancer Resource Services (CRS) ■ Hospital Inpatient Stay	75% after you meet the Annual Deductible
Congenital Heart Disease (CHD) Surgeries	75% after you meet the Annual Deductible
Dental Services - Accident Only	75% after you meet the Annual Deductible
Diabetes Services ■ Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 15, *Prescription Drugs.*
Durable Medical Equipment (DME)	75% after you meet the Annual Deductible
Emergency Health Services - Outpatient Emergency services received at a non-Network Hospital are covered at the Network level.	75% after you meet the Annual Deductible
Extreme Vision	75% after you meet the Annual Deductible
Hearing Aids	75% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Home Health Care Up to 30 visits per calendar year	75% after you meet the Annual Deductible
Hospice Care	75% after you meet the Annual Deductible
Hospital - Inpatient Stay	75% after you meet the Annual Deductible
Kidney Resource Services (KRS) (These Benefits are for Covered Health Services provided through KRS only)	75% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics – Outpatient	75% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient	75% after you meet the Annual Deductible
Mental Health Services ■ Hospital - Inpatient Stay ■ Physician's Office Services	 75% after you meet the Annual Deductible 75% after you meet the Annual Deductible
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders ■ Hospital - Inpatient Stay ■ Physician's Office Services	 75% after you meet the Annual Deductible 75% after you meet the Annual Deductible
Nutritional Counseling	75% after you meet the Annual Deductible
Obesity Surgery ■ Physician's Office Services ■ Physician Fees for Surgical and Medical Services ■ Hospital - Inpatient Stay See Section 6, *Additional Coverage Details* for limits	75% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Ostomy Supplies	75% after you meet the Annual Deductible
Pharmaceutical Products – Outpatient	75% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	75% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	75% after you meet the Annual Deductible
Pregnancy - Maternity Services ■ Physician's Office Services ■ Hospital - Inpatient Stay ■ Physician Fees for Surgical and Medical Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	100% Deductible does not apply 75% after you meet the Annual Deductible 75% after you meet the Annual Deductible
Preventive Care Services ■ Breast Pump ■ Physician Office Services ■ Lab, X-ray or Other Preventive Tests	100% 100% 100%
Private Duty Nursing - Outpatient Up to 30 visits per calendar year	75% after you meet the Annual Deductible
Prosthetic Devices	75% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan: Network
Reconstructive Procedures	
■ Physician's Office Services	75% after you meet the Annual Deductible
■ Hospital - Inpatient Stay	75% after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services	75% after you meet the Annual Deductible
■ Prosthetic Devices	75% after you meet the Annual Deductible
■ Surgery - Outpatient	75% after you meet the Annual Deductible
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits	75% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	75% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 120 days per calendar year	75% after you meet the Annual Deductible
Substance Use Disorder Services	
■ Hospital - Inpatient Stay	75% after you meet the Annual Deductible
■ Physician's Office Services	75% after you meet the Annual Deductible
Surgery – Outpatient	75% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	75% after you meet the Annual Deductible
Therapeutic Treatments – Outpatient	75% after you meet the Annual Deductible
Transplantation Services (If services rendered by a Designated Facility)	75% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Travel and Lodging (If services rendered by a Designated Facility)	For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment or transplant procedures
Urgent Care Center Services	75% after you meet the Annual Deductible
Wigs Up to $300 per calendar year.	75% after you meet the Annual Deductible

[1]In general, your Network provider must notify Personal Health Support, as described in Section 4, before you receive certain Covered Health Services. There are some Network Benefits, however, for which you are responsible for notifying Personal Health Support. See Section 6, *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services -Sickness and Injury*, *Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Lab, X-Ray and Diagnostics - Outpatient*, and *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient.*

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call Personal Health Support.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy when both of the following are true:

- another method of pain management has failed; and
- the service is performed by an MD in the provider's office.

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 14, *Glossary* for the definition of Emergency.

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

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or

- visit www.urncrs.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits for Network services 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.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Facility.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include 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
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, 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.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Dental Services - Accident Only

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

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from 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 occurs 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 Injury and if extenuating circumstances exist due to the severity of the Injury.)

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:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

- 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; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Please remember that you should notify Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment. If you don't notify Personal Health Support, Benefits will be reduced by $250.

Diabetes Services

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

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.
Diabetic Self-Management Items	Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 15, *Prescription Drugs*.

Durable Medical Equipment (DME)

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

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in 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. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- burn garments;
- filters for sleep apnea machines;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, including 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 orthotic devices and 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 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. Benefits are limited as stated below.

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

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

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

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including 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 anytime and are not subject to the three year timeline for replacement.

Emergency Health Services - Outpatient

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

If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, no Benefits will be paid.

Extreme Vision

The Plan's pays for Benefits for the following:

- necessary contact lenses or eyeglasses to correct vision problems following cataract surgery; and

- evaluation, fitting cost and purchase cost of contact lenses if there is a diagnosis of Karatoconus.

Benefits are limited to once every 12 months.

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 do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons 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.

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 in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, intermittent schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

Personal Health Support 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" simply because there is not an available caregiver.

Benefits are limited to 30 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician service for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital 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.*

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

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined in Section 14, *Glossary.*

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

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by Personal Health Support; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, 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.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include, but are not limited to:

- lab and radiology/x-ray; and
- mammography.

Benefits under this section include:

- 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*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services 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:

- the facility charge and the charge for supplies and equipment;
- 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.*

Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services; and
- crisis intervention.

Benefits include the following ser vices provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

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. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. 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 Covered Person and is not mandatory.

Please remember you should notify the MH/SUD Administrator to receive these Benefits in advance of any treatment. Please call the phone number that appears on your ID card.

Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders

The Plan pays Benefits for psychiatric services for Autism Spectrum 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 or property and impairment in daily functioning.

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

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provided-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care with regard to services for Autism Spectrum Disorder. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Please remember you should notify the MH/SUD Administrator to receive the Benefits for Autism Spectrum Disorder in advance of any treatment. Please call phone number that appears on your ID card.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional for Covered Persons with diabetes that require a special diet.

Obesity Surgery

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician.

Morbid obesity means morbid or clinically severe obesity correlated with a Body Mass Index (BMI) of 40 kg/m2 or with being 100 pounds over ideal body weight and 30% over ideal body weight with underlying medical conditions

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Surgery is limited to a lifetime benefit of $5,000. There is no calendar year limit for non-surgical treatment.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits

under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Physician Fees for Surgical and Medical Services

The Plan pays 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 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 allergy injections and hearing exams in case of Injury or Sickness.

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

Pregnancy - Maternity Services

Employee and Dependent Spouse Only

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for postnatal care, delivery, and any related complications.

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 Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

For Dependent Children Only

Pregnancy Benefits for Dependent children are limited to Covered Health Services for Complications of Pregnancy. For a complete definition of Complications of Pregnancy, see Section 14, *Glossary.*

Benefits are payable for Covered Health Services for the treatment of Complications of Pregnancy given to a Dependent child while covered under this Plan.

Benefits for Complications of Pregnancy are paid in the same way as benefits are paid for Sickness.

Benefits for Complications of Pregnancy which result in the delivery of a child are payable for at least:

- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery; and
- 96 hours of inpatient care for the mother and newborn child following a cesarean section.

The following are not considered Complications of Pregnancy:

- false labor;
- occasional spotting;
- rest prescribed by a Physician;
- morning sickness; and
- other conditions that may be connected with a difficult pregnancy but are not a classifiably distinct complication.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

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

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

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Benefits are limited to 30 visits per Covered Person per calendar year.

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 provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

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 would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. 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.

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. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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 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 the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. 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 14, *Glossary*.

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

> Please remember that you should notify Personal Health Support five business days before undergoing a Reconstructive Procedure. When you provide notification, Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;

- Manipulative Treatment;
- speech therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Benefits are limited to:

- 20 visits per calendar year for physical therapy;
- 20 visits per calendar year for occupational therapy;
- 20 visits per calendar year for speech therapy;
- 20 visits per calendar year for Manipulative Treatment.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays 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 those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

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

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 arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physicians services for radiologists, anesthesiologists and pathologists.

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, including anesthesiologists, consulting Physicians, pathologists and radiologists, are described in this section under *Physician Fees for Surgical and Medical Services.*

UnitedHealthcare 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
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

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

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons 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 14, *Glossary.*

Benefits are limited to 120 days per calendar year.

Substance Use Disorder Services

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

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management;
- crisis intervention; and
- detoxification (sub-acute/non-medical).

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

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. The Substance Use Disorder Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use 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 Covered Person and is not mandatory.

Please remember you should notify the MH/SUD Administrator to receive these Benefits in advance of any treatment. Please call phone number that appears on your ID card.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

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

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

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

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 arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *U.S. Food and Drug Administration (FDA)*-approved TMJ implants only when all other treatment has failed.

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.

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 healthcare professionals when:

- education is 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.

Benefits under this section include:

- 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.*

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network provider and received at a Designated Facility. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. 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 that are provided by a Network provider at a Network Hospital. You are not required to notify United Resource Networks or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

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.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the telephone number on your ID card for information about these guidelines.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Facility.

Travel and Lodging

United Resource Networks or Personal Health Support will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD);
- transplantation services; and
- cancer-related treatments.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment, the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $75 per day for the patient or up to $100 per day for the patient plus one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility (for CRS and transplantation) or the CHD facility. UnitedHealthcare

must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

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.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *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.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis regardless of the reason of hair loss.

Benefits are limited to $300 per calendar year.

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

City of Dallas believes in giving you the tools you need to be an educated health care consumer. To that end, City of Dallas has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
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 own health. UnitedHealthcare and City of Dallas 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 text.

Consumer Solutions and Self-Service Tools

Employee Assistance Program (EAP)

UnitedHealthcare offers free counseling and referral services nationwide through the Employee Assistance Program (EAP). Using a solution focused approach to care, they tailor their interventions to meet your individual needs. The program can help you and your immediate family members cope with issues such as:

- family or relationship problems;
- parenting difficulties;
- work-related problems;
- financial and legal issues;
- substance use or abuse;
- grief and loss; and
- anxiety.

Call the toll-free phone number on the back of your ID card to speak to a specially trained, master's-level specialist who will recommend the right resources for your specific life

concern. Services are available any time, 24 hours a day, seven days per week and are strictly confidential in accordance with state and federal laws.

Health Assessment

You are invited to learn more about your health and wellness at **www.myuhc.com** 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, except as stated in Section 17.

To find the health assessment, log in to **www.myuhc.com**. 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 the number on the back of your ID card.

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;
- smoking 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 – City of Dallas' way of helping you meet your health and wellness goals.

NurseLine℠

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. 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 City of Dallas 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 in Spanish.

NurseLine is available to you at no cost.

Note: If you have a medical emergency, call 911 instead of calling NurseLine.

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. 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** 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 logging onto **www.myuhc.com**.

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 the number on the back of your ID card.

UnitedHealth Premium℠ Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium 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 and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- 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;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;

- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** 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 Physician.

Disease and Condition Management Services

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 even 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 and 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 the number on the back of your ID card.

HealtheNotes℠

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

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

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

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

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. 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 the toll-free number on the back of your ID card.

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.

SECTION 8 - 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, *Additional Coverage Details.*

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also 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, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

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

Alternative Treatments

1. acupressure
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. Rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details.*

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

   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. Examples include treatment

of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

   - extractions (including 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 accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details.*

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

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details.*

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

   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 for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details.*

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

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, *Additional Coverage Details*.

   Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter.

3. cranial banding;

4. the following items are excluded, even if prescribed by a Physician:

   - blood pressure cuff/monitor;
   - enuresis alarm;

- non-wearable external defibrillator;
- trusses;
- ultrasonic nebulizers;

5. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

6. the replacement of lost or stolen prosthetic devices;

7. 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, *Additional Coverage Details* ; and

8. oral appliances for snoring.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the prescription portion of the Plan, which is administered by Caremark. Please visit **www.caremark.com** or call the number on your ID Card for more information.

1. Prescription Drugs for outpatient use that are filled by a prescription order or refill;

2. self-injectable medications (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);

3. growth hormone therapy;

4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and

5. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *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.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details.* Routine foot care services that are not covered include:

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

2. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet;
   - 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;

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. treatment of flat feet;

4. shoe inserts;

5. arch supports;

6. shoes (standard or custom), lifts and wedges; and

7. shoe orthotics.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

   - elastic stockings, ace bandages, diabetic strips, and syringes; and
   - urinary catheters.

This exclusion does not apply to:

- ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details.*
- disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*; or
- diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details.*

2. 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; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details.*

Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders* [2] and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details.*

1. services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that , in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:

3. not consistent with generally accepted standards of medical practice for the treatment of such conditions;

4. not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;

5. not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or

6. not clinically appropriate for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

7. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

8. Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;

9. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal);

10. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;

11. tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act;

12. learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

13. mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

14. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction; and

15. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

1. nutritional or cosmetic therapy using high dose 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*, and except as defined under *Nutritional Counseling* in Section 6, *Additional Coverage Details*;

3. food of any kind. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are the only source of nutrition and even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - foods to control weight, treat obesity (including 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 and electrolyte supplements; and

4. 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. supplies, equipment and similar incidentals for personal comfort. Examples include:

   - air conditioners;
   - air purifiers and filters;

- batteries and battery chargers;
- dehumidifiers and humidifiers;
- ergonomically correct chairs;
- non-Hospital beds, comfort beds, motorized beds and mattresses;
- breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
- car seats;
- chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
- electric scooters;
- 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; and
- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact 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, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity; and

4. treatment of benign gynecomastia (abnormal breast enlargement in males).

Preexisting Conditions

1. Benefits for the treatment of a Preexisting Condition are excluded unless you have had Continuous Creditable Coverage for 12 months. Preexisting Condition is defined in Section 14, *Glossary*.

   This exclusion does not apply to Covered Persons under age 25.

Procedures and Treatments

1. biofeedback;

2. 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);

3. rehabilitation services and Manipulative 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;;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

8. psychosurgery (lobotomy);

9. treatment of tobacco dependency;

10. chelation therapy, except to treat heavy metal poisoning;

11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, such as asthma or allergies;

12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

13. sex transformation operations;

14. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*;

15. medical and surgical treatment of hyperhidrosis (excessive sweating);

16. the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations;

17. upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor or cancer. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment, except as treatment of obstructive sleep apnea; and

18. breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

- prior to ordering the service; or
- after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

1. health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment

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

2. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);

3. surrogate parenting, donor eggs, donor sperm and host uterus;

4. the reversal of voluntary sterilization;

5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

6. prenatal, labor and delivery coverage for enrolled Dependent children except those that have Complications of Pregnancy as defined in Section 14, Glossary;

7. fetal reduction surgery;

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

   This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

9. contraceptive supplies and services(certain contraceptives are covered at 100%, not subject to the Annual Deductible, per Health Care Reform. Contact UnitedHealthcare for additional information);

10. services provided by a doula (labor aide); and

11. parenting or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);

3. transplants that are not performed at a Designated Facility (this exclusion does not apply to cornea transplants); and

4. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details.* Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary;*

3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

4. Private Duty Nursing received on an inpatient basis;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in Section 6, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants; and

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;

2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

3. purchase cost and associated fitting charges for eyeglasses or contact lenses;

4. bone anchored hearing aids except when either of the following applies:

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

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

5. eye exercise or vision therapy; and

6. 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; or
   - 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; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

- that do not meet the definition of a Covered Health Service in Section 14, *Glossary*;
- that 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 Covered Persons 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 which 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 Benefit Plan; or
- that exceed Eligible Expenses or any specified limitation in this SPD;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; and

8. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

- required solely for purposes of education, sports or camp, insurance, marriage or adoption; or as a result of incarceration;
- conducted for purposes of medical research;
- related to judicial or administrative proceedings or orders; or
- required to obtain or maintain a license of any type.

9. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

SECTION 9 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

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 the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and 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 Benefits

If you receive a bill for Covered Health Services from a non-Network provider as a result of an Emergency, 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 address on the back of your ID card.

Prescription Drug Benefit Claims

Prescription coverage is available through Caremark. For information on submitting your outpatient prescription drug claims, call the toll-free number on your ID Card or visit **www.caremark.com**.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting City of Dallas Benefit Service Center. 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 patient's name, age and relationship to the Participant;
- the number as shown on your 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 carrier(s).

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

The above information should be filed with us at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the 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 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, your provider, and not to a third party, even if your provider has assigned Benefits to that third party.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. 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 paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Claims
All claim forms must be submitted within 12 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 City of Dallas. This 12-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 the number on your ID card 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, post-service claim or a rescission of coverage determination as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the 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 request.

You or your enrolled Dependent may send a written request for an appeal to:

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

Customer Service: 800-736-1364

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card 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;
- post-service claim; or
- concurrent claim.

Review of an 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 will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from City of Dallas within 60 days from receipt of the first level appeal determination. City of Dallas must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. City of Dallas will review all claims in accordance with the rules established by the U.S. Department of Labor. City of Dallas's decision will be final.

Federal External Review Program

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

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

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or

- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card 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 received City of Dallas' decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; 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; and
- a decision by the IRO.

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

- is or was covered under the 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 a notification in writing to you. 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.

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 of receipt of the notice additional information that the IRO will 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.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making City of Dallas' determination. The documents include:

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

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by City of Dallas. 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 they request 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 City of Dallas' determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. 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.

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 individual or would jeopardize the individual'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 timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual'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 individual received emergency services, but has not been discharged from a facility.

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

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

After UnitedHealthcare completes 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 City of Dallas. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and

- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
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**
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
City of Dallas must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal**

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

**City of Dallas may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
City of Dallas must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal*

*UnitedHealthcare may be entitled to a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

**City of Dallas may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

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 timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against City of Dallas or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against City of Dallas or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against City of Dallas or the Claims Administrator.

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

SECTION 10 - 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 any one of the following:

- another employer sponsored health benefits 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 auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

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 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** or call the toll-free number on your ID card 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:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

- 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 pays benefits first is the one that has been in effect the longest. 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 without specifying that one party 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;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; Only expenses normally paid by the Plan will be paid under COB; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

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 Participant 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.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the primary plan's allowable expense.
- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.

- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense When This Plan is Secondary

When this Plan is secondary, the allowable expense is the primary plan's Network rate. 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.

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

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

- employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary

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 are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Right to Receive and Release Needed Information

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

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

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 UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If City of Dallas pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to City of Dallas if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment City of Dallas made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

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

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

SECTION 11 - 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 you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent 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 provides an advancement of benefits to you or your Dependent during the time period of the Deductible and/or meeting the 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 it has advanced 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 you 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 considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a

Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

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

Right to Reimbursement

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

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity who caused the Sickness, Injury or damages;
- City of Dallas in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers' compensation coverage; or
  - any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
- the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- 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) or judgment, 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.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - complying with the terms of this section;
  - providing any relevant information requested;
  - signing and/or delivering documents at its request;
  - notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - responding 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 before releasing any party from liability or payment of medical expenses.
- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- you may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- 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 provided for a Sickness or Injury caused by a third party.
- the Plan's rights will not be reduced due to your own negligence.
- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including 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 apply to the parents, guardian, or other representative of a Dependent child 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.
- 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.

- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- if a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Subrogation – 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. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

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

When your coverage ends, City of Dallas 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 coverage ended, even if the underlying medical condition occurred before your coverage ended.

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

- the last day of the month your employment with the Company ends;
- the date the Plan ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you are no longer eligible;
- the last day of the month UnitedHealthcare receives written notice from City of Dallas to end your coverage, or the date requested in the notice, if later; or
- the last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

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

- the date your coverage ends;
- the last day of the month you stop making the required contributions;
- the last day of the month UnitedHealthcare receives written notice from City of Dallas to end your coverage, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

The Plan will provide written notice to you that your coverage has ended if any of the following occur:

- you permit an unauthorized person to use your ID card or you use another person's ID card;
- you knowingly give UnitedHealthcare false material information including, but not limited to, false information relating to another person's eligibility or status as a Dependent;

- you commit an act of physical or verbal abuse that imposes a threat to City of Dallas' staff, UnitedHealthcare's staff, a provider or another Covered Person; or
- you violate any terms of the Plan.

Note: City of Dallas has the right to demand that you pay back Benefits City of Dallas paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to City of Dallas proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon City of Dallas' request, that the child continues to meet these conditions.

The proof might include medical examinations at City of Dallas' expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under COBRA.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if City of Dallas is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

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

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

- a Participant;

- a Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines 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 considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months 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 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.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. 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 Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

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

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction.*

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation 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 the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

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

Once you have notified the Plan Administrator, 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 City of Dallas Benefit Service Center 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 the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator 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 Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

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

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- 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 Participant 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 Participant and the Participant'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, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required

to pay more than the regular contribution amount, if any, for continuation of health coverage.

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

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

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant'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 the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

Survivorship Coverage

If the employee dies while covered under the Plan, the surviving spouse and any eligible dependents may continue coverage under the Plan until the end of the month following a period of 90 days subsequent to the employee's death. After the initial 90 days following the employee's date of death, coverage is then available to the surviving spouse and any eligible dependents through the COBRA provision, except for a surviving spouse of an active uniformed officer killed in the line of duty. A surviving spouse of an active uniformed officer may continue coverage on the existing plan at active rates. If a surviving spouse remarries, coverage under the Plan will terminate.

A surviving spouse who is covered under a retiree Plan may continue coverage as long as he/she is eligible for pension benefits. Any dependents acquired through the remarriage of a retired employee's surviving spouse will not be eligible for coverage under the Plan.

A surviving spouse and eligible dependents of a retired employee may remain in the Plan after the death of the retired employee:

- If the person was covered as a dependent spouse of the deceased retired employee at the time of the retired employee's death and is eligible to receive pension benefits;
- If carried as a dependent child, the person remains a dependent of the surviving spouse, but only if the spouse is receiving monthly survivor's benefits from one of the retirement funds.

Coverage for all surviving dependents ceases if coverage for the surviving spouse stops because of death, termination of monthly benefits, or any other reason.

A retired employee, or a surviving spouse or dependent who is eligible for Medicare participation by reason of age or disability or any other reason, must enroll and remain enrolled in Medicare Parts A and B in order to retain eligibility in the Plan.

The City will pay the Medicare Part A monthly premium on behalf of the retired employees and spouses of retired employees who are not otherwise qualified for Medicare. Retired employees are responsible for notifying the City, otherwise, they will be responsible for payment of the Medicare Part A premium. The retired employee and retired employee's spouse are responsible for payment of all Medicare Part B premiums.

If a retired employee is enrolled in this Plan on January 1, and elects to discontinue coverage in this Plan, the retired employee will not be eligible to enroll at a later date or in a subsequent plan

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and City of Dallas;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

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 medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

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 City of Dallas

In order to make choices about your health care coverage and treatment, City of Dallas believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- City of Dallas and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

City of Dallas and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. City of Dallas and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. City of Dallas and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between City of Dallas, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not City of Dallas' agents or employees, nor are they agents or employees of UnitedHealthcare. City of Dallas and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

City of Dallas and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, City of Dallas and UnitedHealthcare arranges for health care providers to participate in a Network and pay Benefits. 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. They are not City of Dallas' employees nor are they employees of UnitedHealthcare. City of Dallas and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. City of Dallas and UnitedHealthcare are not liable for any act or omission of any provider.

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

City of Dallas and the Plan Administrator are solely responsible for:

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

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;

- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

City of Dallas and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

City of Dallas and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

Information and Records

City of Dallas and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. City of Dallas and UnitedHealthcare may request additional information from you to decide your claim for Benefits. City of Dallas and UnitedHealthcare will keep this information confidential. City of Dallas and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

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

City of Dallas and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan,

for appropriate medical review or quality assessment, or as City of Dallas is required to do by law or regulation. During and after the term of the Plan, City of Dallas and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements City of Dallas 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, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, City of Dallas and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

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

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but City of Dallas recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

City of Dallas and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. City of Dallas and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD 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 SPD, but it does not describe the Benefits provided by the Plan.

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

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 Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount of Eligible Expenses you must pay for Covered Health Services in a calendar year before you are eligible to begin receiving Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights.*

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

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

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).

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

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

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as UnitedHealthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

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 patient is not allowed to choose which treatment will be received.

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.*

Company – City of Dallas.

Complications of Pregnancy – a condition suffered by a Dependent child that requires medical treatment before or after Pregnancy ends.

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

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects 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 to certain employees and their dependents whose group health insurance has been terminated.

Continuous Creditable Coverage – health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- a group health plan;
- health insurance coverage;
- Medicare;
- Medicaid;
- medical and dental care for members and certain former members of the uniformed services, and for their dependents;
- a medical care program of the Indian Health Services Program or a tribal organization;
- a state health benefits risk pool;
- The Federal Employees Health Benefits Program;
- The State Children's Health Insurance Program (S-CHIP);
- health plans established and maintained by foreign governments or political subdivisions and by the U.S. government;
- any public health benefit program provided by a state, county, or other political subdivision of a state; or
- a health benefit plan under the Peace Corps Act.

If you or your eligible Dependents were covered by any of the above plans before first becoming covered by this Plan, you should have received a Certificate of Creditable Coverage when that plan's coverage ended.

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 Claims Administrator. 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 function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which City of Dallas determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms;
- consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below;

- not provided for the convenience of the Covered Person, Physician, facility or any other person;
- included in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community; and
- "prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

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, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient 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.

Deductible – see Annual Deductible.

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

Designated Facility – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specific conditions.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between a Participant and one other person of the same sex. Both persons must:

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent and have furnished documents to support at least two of the following conditions of such financial interdependence:
  - they have a single dedicated relationship of at least 6 months duration;
  - they have joint ownership of a residence; or
  - they have at least two of the following:
    - a joint ownership of an automobile;
    - a joint checking, bank or investment account;
    - a joint credit account;
    - a lease for a residence identifying both partners as tenants; or
    - a will and/or life insurance policies which designate the other as primary beneficiary.

The Participant and Domestic Partner must jointly sign an affidavit of domestic partnership provided by City of Dallas Benefit Service Center upon your request.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – charges for Covered Health Services that are provided while the Plan is in effect, determined as follows:

For:	Eligible Expenses are Based On:
Network Providers	contracted rates with that provider
Non-Network Providers	If you receive Covered Health Services from a non-Network provider in an Emergency, Eligible Expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or Substance Use Disorders 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.

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

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – City of Dallas.

EOB – see Explanation of Benefits (EOB).

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

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

Exceptions:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and City of Dallas may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UnitedHealthcare and City of Dallas must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

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

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, 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 or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

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

Inpatient Rehabilitation Facility – a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides physical therapy, occupational therapy and/or speech therapy on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

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

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by City of Dallas. The KRS program provides:

- specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

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

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

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

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

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the organization or individual designated by City of Dallas who provides or arranges Mental Health 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*, unless they are listed in Section 8, *Exclusions.*

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by City of Dallas. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator'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 some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network provider. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Open Enrollment – the period of time, determined by City of Dallas, during which eligible Participants may enroll themselves and their Dependents under the Plan. City of Dallas determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

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

Participant – a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Personal Health Support – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

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 – 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.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that 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 City of Dallas Medical Plan.

Plan Administrator – City of Dallas or its designee.

Plan Sponsor – City of Dallas.

Preexisting Condition – any Sickness or Injury that is identified by the Plan Administrator as having been diagnosed or treated, or for which Prescription Drugs were prescribed or taken within the six months before coverage under this Plan begins (or the first day of any waiting period, if earlier). A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.

If you have Continuous Creditable Coverage, you or your Dependent will be eligible to receive Plan Benefits for a Preexisting Condition. Continuous Creditable Coverage is defined in this section.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with Pregnancy.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

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 surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

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

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the 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.

Retired Employee – an Employee who retires while covered under the Plan.

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

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider.

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

Skilled Care – skilled nursing, teaching, and 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 patient;
- 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.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Specialist Physician.

Spouse – an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded.

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, 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 Covered Person with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members 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 doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program – a program that identifies network Physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the 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 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**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and City of Dallas may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and City of Dallas must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.
- UnitedHealthcare and City of Dallas may, in their discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that UnitedHealthcare and City of Dallas do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies must be available in published peer-reviewed medical literature that would allow UnitedHealthcare and City of Dallas to conclude that the service is promising but unproven.
  - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare and City of Dallas's discretion. Other apparently similar promising but unproven services may not qualify.

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 minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

UnitedHealthcare Services, Inc.
185 Asylum Street
Hartford, CT 06103-3408

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

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Services, Inc.. The named fiduciary of Plan is City of Dallas, the Plan Sponsor.

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

SECTION 16 HEALTH REIMBURSEMENT ACCOUNT

This section describes the healthcare expense reimbursement component of the Plan. It includes summaries of:

- What is a Health Reimbursement Account (HRA);
- Who is eligible and how to enroll;
- How the HRA works;
- Claim procedures and requesting reimbursement from your HRA.
- HRA Glossary

Notice to Employees

This section of the Summary Plan Description (SPD) describes the Employer-sponsored Health Reimbursement Account (HRA).

City of Dallas has entered into an agreement with UnitedHealthcare Services, Inc., Hartford, CT, ("UnitedHealthcare") under which UnitedHealthcare will process eligible healthcare expense reimbursements through the HRA and provide certain other administrative services pertaining to the Plan. UnitedHealthcare does not insure the benefits described in this section.

Quick Reference Box

- Member services and claim inquiries, use the Customer Service number on the back of your ID card or call 1-800-645-6555;
- UnitedHealthcare HRA Claims submittal address: UnitedHealthcare – HRA Group Claims, P.O. Box 981178, El Paso, TX 7998-1178; and
- Online assistance: **www.myuhc.com**

WELCOME - HRA

This section of your Summary Plan Description (SPD) describes the Health Reimbursement Account (HRA) available to you and your eligible dependents enrolled in the Plan.

A Health Reimbursement Account is a financial account that allows City of Dallas to reimburse you for health expenses paid by you, under the associated medical plan, to offset health care costs.

It is your responsibility to manage your HRA account balance. We offer several tools to help you; refer to Section 7 – Resources to Help You Stay Healthy for information on health and well-being resources available to you, or visit **www.myuhc.com** for access to a treatment cost estimator. Once you spend your entire HRA balance, you are responsible for paying expenses as described in your SPD.

You can keep track of the funds in your HRA by going online to **www.myuhc.com**, by calling the toll-free number on the back of your ID card or by checking your monthly member statement sent to you by UnitedHealthcare.

Please read this section thoroughly to learn how the HRA component of the Plan works. If you have questions call the number on the back of your ID card. Capitalized terms not otherwise defined in this section have the meaning set forth in the SPD, Section 14 – Glossary.

What is a Health Reimbursement Account?

Health Reimbursement Accounts are "unfunded" accounts; otherwise known as a demand deposit account. City of Dallas is not required to prepay into it, instead, funds allocated to the HRA are made available to reimburse you for claims as they occur. All contributions allocated to your HRA are owned, controlled and payable solely from the general assets of City of Dallas. You are not permitted to make any contribution to the HRA, whether made on a pre-tax or after-tax basis. In addition:

- The HRA is established by City of Dallas and administered by UnitedHealthcare in accordance with applicable provisions of the Internal Revenue Service Code and associated guidance issued by the IRS/Treasury Department.
- City of Dallas determines which Internal Revenue Code 213d health expenses will be eligible for reimbursement through the HRA.
- There is no limit to the contributions City of Dallas can choose to allocate to your account.
- Employer Contributions allocated to your HRA can be excluded from your gross income.
- City of Dallas will decide how to handle unused funds at the end of the calendar year. Unused funds are not transferable if your employment with City of Dallas ends.
- You can participate in an HRA and a Flexible Spending Account (FSA) at the same time. However, City of Dallas will determine the order under which claims may be reimbursed from the HRA or FSA.

INTRODUCTION - HRA

Who Is Eligible for the HRA And How To Enroll

You must be covered under a medical plan in order to participate in the HRA. You are enrolled in the HRA at the same time you enroll in your medical plan. You cannot elect it separately and you can't withdraw from it unless you also withdraw from the medical plan. Eligibility to participate in the Plan is described in the SPD, section 2 –Introduction. Contact City of Dallas Benefit Service Center if you have questions about eligibility and enrollment.

Each year during annual Open Enrollment, you have the opportunity to review and change your benefit election. Any changes you make during Open Enrollment will become effective as described in the SPD, section 2 –Introduction.

Important
If you wish to change your benefit elections following a marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact City of Dallas Benefit Service Center as described in the medical plan SPD, section 2 – Introduction under the heading *Changing You Coverage*. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

Cost of Coverage

You and City of Dallas share in the cost of the medical plan, there is no charge to you for participation in the financial account component of your Plan. Your contribution amount, (also known as a premium) depends on the medical plan you select and the family members you choose to enroll.

Your medical plan premium is deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. For more information on the Cost of Coverage please refer to the SPD, section 2 –Introduction under the heading *Cost of Coverage.*

Changing Your HRA Coverage

If you are hired during the Plan year or are enrolling in the Plan mid-year during a special enrollment period, coverage will become effective as described in the SPD, section 2 – Introduction under the heading *Changing Your Coverage.*

For detail on the Employer Contribution to your HRA for mid-year enrollment and/or status changes see this Section 17 – Health Reimbursement Account under heading *How the Plan Works*, and look for "New Hires and Adjustments for Status Changes".

For information on ending your coverage please refer to this Section 17 –Health Reimbursement Account of the SPD, under the header *When HRA Coverage Ends.*

HOW THE HRA WORKS

How much money is allocated to your HRA – Employer Contributions

City of Dallas will allocate a specified amount of funds to your HRA on a calendar year basis specific to the coverage category you enroll in. For each claim presented to the HRA, available funds will be used to pay for Eligible Medical Expenses. The table below contains the details for the Employer Contribution to your HRA:

Coverage Category	Annual Employer Contribution to your HRA[1]
1.Employee Only or	$700*
2.Family	$1,700*

[1]This is the only amount that will be placed in your HRA during the calendar year and may be used for Eligible Expenses.

* Employees who complete a Health Assessment online @ www.myuhc.com between January 1, 2011 and February 28, 2011 will be awarded an additional $300 dollars.

New Hires And Adjustments For Status Changes

Mid-Year Enrollment

If you are hired during the Plan year or are enrolling in the Plan mid-year during a special enrollment period as a result of a change in status, the amount of the Employer Contribution allocated to your HRA will be prorated on a monthly basis, effective retroactive to the first day of the month in which you are enrolled in the Plan.

Status Changes

When you switch among Coverage Categories the City of Dallas' contribution amount allocated to your HRA may increase or decrease by category.

Under the Plan, if you increase your category (e.g. self to self plus family) the Employer Contribution to your HRA is adjusted to your new category for that Plan year minus any amounts already accumulated or used in that Plan year.

If you decrease your category (e.g. you change from self plus family to self) the Employer Contribution to your HRA is *not* adjusted to your new category for that Plan year.

Rehires

If during a Plan year, you are enrolled in an active medical plan as described in your medical plan SPD and you are rehired by City of Dallas following your employment termination date and re-enroll in the active medical Choice HRA plan, City of Dallas will allocate the HRA Contribution amount equal to the amount a newly hired active employee would be eligible for. (See this section under the heading *Mid-Year Enrollment.*)

You can keep track of the funds in your HRA by going online to **www.myuhc.com**, by calling the toll-free number on the back of your ID card or by checking your monthly member statement sent to you by UnitedHealthcare.

What Expenses Are Payable From Your HRA

The HRA reimburses all amounts due from claims for medical expenses that are eligible from the underlying medical plan, plus any claims for pharmacy expenses. Eligible expenses include Annual Deductible, Coinsurance and Copayments.

Order of Accounts

If you choose to participate in multiple spending accounts be aware that a payment hierarchy does exist. The order in which your accounts must be used for reimbursements is described in the table below:

Account	Hierarchy Order Of Accounts
1. FSA Grace Period	First
2. Health Reimbursement Account (HRA)	Second
3. FSA	

While the HRA and FSA may cover some of the same types of expenses, the FSA may be funded with pre-tax contributions under a salary reduction arrangement.

Expenses reimbursed through the HRA cannot also be reimbursed through the FSA.

What Happens to Remaining Balances in the HRA?

If you don't spend all the funds in your HRA during the initial calendar year, and you re-enroll in the HRA for the following year, any remaining HRA balance up to $6,000 rolls over into your account for the next calendar year. In this manner your HRA may "grow" almost like a savings account.

If you don't re-enroll in the HRA for the following year, you forfeit any unused funds remaining in the account.

CONSUMER ACCOUNTS MASTERCARD® CARD

Consumer Accounts MasterCard® Card

The Consumer Accounts Card is a payment mechanism that allows members a means for direct payment of Eligible Expenses, per your specific plan design described under section, Your HRA, to UnitedHealthcare network providers, Drugstore.com, Walgreen's and participating merchants. Payment for Eligible Expenses comes directly from your HRA and eliminates the need for most paper claims. You will be provided with two Consumer Accounts Cards, with terms and conditions and activation information that may be used at certain locations where MasterCard® is accepted. Contact the customer service number listed on the back of the Consumer Accounts Card with questions or to request additional cards.

Use of the Consumer Accounts Card is voluntary. The card must be activated prior to use. When you activate the Consumer Accounts Card:

1. Prior to the plan effective date, wait one (1) business day after the plan effective date before you utilize your card;

2. After the plan effective date, the card will be ready to use one (1) business day following activation.

UnitedHealthcare Network Providers and Participating Merchants

The consumer website, www.myuhc.com, contains a directory of medical, dental and vision providers in UnitedHealthcare's provider network. While network status may change from time to time, www.myuhc.com has the most current source of provider network information. Use myuhc.com to search for network providers available in your specific plan design.

Participating drug store and pharmacy merchants comply with specific methods used to identify and substantiate eligible expenses, per the United States Internal Revenue Code of 1986 ("IRC"), as amended from time to time. You can see a full list of participating merchants at http://www.sig-is.org. Participating merchants identify what is an eligible expense under 213d of the IRC, they do not identify eligible HRA expenses at point of sale based on your specific plan design.

Using the Consumer Accounts Card

The Consumer Accounts Card may not be used at point of sale to make a purchase from non-participating merchants. You will need to pay using another form of payment, and then submit eligible expense receipts for reimbursement as described under the section, Requesting Reimbursement from your HRA.

The Consumer Accounts Card may be used for a point of sale purchase at any UnitedHealthcare network provider or participating merchant with a Point-of-Service (POS) bankcard terminal that accepts MasterCard® such as a network hospital, network physician and retail network pharmacy counters.

You may choose to use your Consumer Accounts Card for mail order prescriptions or for over-the-counter items by going to an online pharmacy at Drugstore.com via myuhc.com.

Additionally, your Consumer Accounts Card can be used at Walgreen's retail stores or at participating drug store and pharmacy merchants.

No Personal Identification Number ("PIN") is required when you use the Consumer Accounts Card. At the point of sale choose 'credit' on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your HRA and card are regulated by the Internal Revenue Service, therefore you should retain all itemized receipts generated from the Consumer Accounts Card. Certain payments must be verified and UnitedHealthcare may request this receipt from you to ensure that payment was made for a qualified HRA expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the Consumer Accounts Card through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases in real-time and automatically debits your HRA account based on the guidelines established by the IRS and your specific plan design as described under section, Your HRA. A claim number is assigned to the transaction.

Partial Payment Authorization

Partial authorization capability allows you to use your Consumer Accounts Card with transactions amounts greater than the funds available in your HRA for a portion of the transaction at merchants that accept partial authorization. For example, if you purchase an item that costs $20 and you only have $10 remaining in your HRA, the HRA balance of $10 will be authorized towards the purchase and you are responsible for paying the remaining balance of $10 with another form of payment. Note: not all merchants accept partial authorization.

Member Health Statements and HRA Yearly Statements

Member Health Statements are available on the consumer website, myuhc.com. A member health statement is produced whenever there is claims activity for a member. You will receive monthly health statements and a HRA yearly statement which will include your card activity. If you note a discrepancy with a card transaction, call the number on the back of your Consumer Accounts Card to resolve the issue.

HRA CLAIM PROCEDURES

Claims Submission

City of Dallas has designed your HRA to allow certain claims to be automatically submitted to your account for reimbursement. UnitedHealthcare will coordinate payments from your HRA for medical and pharmacy claims.

You can turn this feature "off" or back "on" via myuhc.com.

There are some types of claims that will not be processed automatically for which you will need to submit a claim; for additional information on these claims see the header below called When to Submit a Claim.

When auto-submission is elected all payments from an HRA will be sent to the provider directly. You will receive the reimbursement when no provider information is available. In the situations listed below, you will receive reimbursement from the HRA:

1. Pharmacy claims
2. Copays
3. Manually submitted claims
4. Claims adjustments

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will process the payment for the medical plans portion of the cost of the Covered Health Services and send it directly to the Physician or facility.

Funds allocated to your HRA will be available to help you pay a portion of your out-of-pocket costs under the medical plan as described in this SPD in Section 3 How the Plan Works. UnitedHealthcare will process the payment for a portion of your cost of the Covered Health Services from available funds in your HRA and send it directly to the Physician or facility automatically. This feature can be turned on and off by accessing myuhc.com. There are some types of claims that will not be paid directly to the provider, they are as follows: Pharmacy Claims, Copays, manually submitted claims, and adjustments and out of network provider claims. These types of claims will always pay you directly.

When to Submit a Claim

You must submit a claim for reimbursement from your HRA for any other types of expenses other than Covered Health Services and any health expenses not submitted to UnitedHealthcare.

If you receive a bill for Covered Health Services from a provider, you 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 HRA Claims submittal address:

UnitedHealthcare – HRA Group Claims
P.O. Box 981178
El Paso, TX 7998-1178

Important - Timely Filing of Claims
All claim forms must be submitted within 90 days 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 City of Dallas. This 90 day requirement does not apply if you are legally incapacitated.

How to File Your Claim

To be reimbursed from your HRA simply submit a reimbursement form, called a Reimbursement Request for Withdrawal Form, for the Eligible Expenses that have been incurred. A Request for Withdrawal Form is available from City of Dallas or on the Internet at **www.myuhc.com**. For reimbursement from your HRA, you must include proof of the expenses incurred. For Eligible Medical Expenses, proof can include a bill, invoice, or an Explanation of Benefits (EOB) from any group medical/dental plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical and dental plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental plans.

Important
You can view EOB's and Health Statements online via myuhc.com. Myuhc.com includes many features such as the option to:
- View your HRA summary page detailing contributions and amount left in your HRA;
- View your HRA Claims Summary including claim transaction details.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. 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 paper copies of the

EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **myuhc.com**. See section 14, *Glossary* for the definition of Explanation of Benefits.

Requesting Reimbursement from Your HRA

If you have funds available in your HRA you may submit a claim for reimbursement for the Eligible Expenses from your HRA. If you do choose to submit a request for reimbursement, the request must be received no later than 90 days following the end of the calendar year in which you are eligible under this Plan. If you don't provide this information to the Claims Administrator within this timeframe, your claim will not be eligible for reimbursement, even if there are funds available in your HRA. This time limit does not apply if you are legally incapacitated.

You cannot be reimbursed for any expense paid under your medical plan. Expenses for which you are reimbursed from your HRA cannot be included as a deduction or credit on your federal income tax return.

Important Note

- The date on which you incurred an eligible medical expense is the date used when deducting amounts from your HRA. This allows your HRA to act like a savings account, available for your use when your claim is paid.

Claims for Reimbursement and Appeals

To be reimbursed from your HRA simply submit a reimbursement form, called a Request for Withdrawal Form, for the eligible expenses that have been incurred. A Request for Withdrawal Form is available from City of Dallas or on the Internet at **www.myuhc.com**. For reimbursement from your HRA, you must include proof of the expenses incurred as indicated on the Request for Withdrawal Form. For eligible expenses, proof can include a bill, invoice, or an Explanation of Benefits (EOB) from any group medical/dental plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical plans.

When filing a claim for reimbursement from your HRA, your claims should be submitted to:

UnitedHealthcare – HRA Group Claims
P.O. Box 981178
El Paso, TX 7998-1178;

Important
You can view EOB/member statements online via myuhc.com. Myuhc.com includes many features such as the option to:

- View your HRA summary page detailing contributions and amount left in your HRA;
- View your HRA Claims Summary including claim transaction details.

For additional information on claims procedures and appeals, please refer to section 9, *Claims Procedures.*

HRA COORDINATION OF BENEFITS (COB)

For information on how your Benefits under this Plan coordinate with other medical plans and how coverage is affected if you become eligible for Medicare, refer to section 10 – Coordination of Benefits (COB).

Overpayment and Underpayment of Benefits

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan. For further information on COB refer to section 10 – Coordination of Benefits (COB).

SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement, as defined in the SPD section 11 – Subrogation and Reimbursement.

WHEN HRA COVERAGE ENDS

Your coverage under the Plan ends as described in the SPD, section 12 – When Coverage Ends.

Continuation of Coverage - Consolidated Omnibus Budget Reconciliation Act ("COBRA")

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the Health Reimbursement Account. You should call City of Dallas to find out whether this Plan is subject to COBRA. If the Plan is subject to COBRA see "Optional Continuation Coverage under your Health Care Spending Account (COBRA)".

COBRA continuation coverage must be offered with respect to a participant's HRA when the Plan is subject to COBRA. If your employment terminates for any reason the funds in your HRA will revert back to us after your claim run-out period, unless you elect COBRA coverage as described in the SPD, section 12 –When Coverage Ends under the heading *Changing You Coverage.* If you elect COBRA coverage, HRA funds will remain available to assist you in paying your out-of-pocket costs under the medical plan while COBRA coverage is in effect. The HRA balances under COBRA are recalculated using the methods elected by City of Dallas for mid-year enrollment and/or status changes; as described in Section 17 – Health Reimbursement Account under heading *How the Plan Works*, and look for "New Hires and Adjustments for Status Changes".

GLOSSARY

What this section includes:
- Definitions of terms used throughout this Section 17.

Many of the terms used throughout this Attachment 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 Attachment, but it does not describe the benefits provided by the Plan. Capitalized terms not otherwise defined in this section have the meaning set forth in your medical plan SPD.

HRA - Health Reimbursement Account or HRA. It is an IRS section 105 and 106 account that follows standard regulations and tax benefits for such accounts. It can only be used for qualified medical expenses.

HRA ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the HRA portion of the Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional information can be found in this SPD, section 16 Plan Administrative Information.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the HRA Plan Benefits described in this Summary Plan Description.

UnitedHealthcare Services, Inc.
185 Asylum Street.
Hartford, CT 06103-3408

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

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

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

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

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

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

> ***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 Summary Plan Description (see Section 5, *Plan Highlights*) 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 Dependents as defined in the Summary Plan Description in Section 14, *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 the number on the back of your ID card.

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 ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your 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 the toll-free phone number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description 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 people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

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 insurance plan for Covered Health Services described in the Summary Plan Description 5, *Plan Highlights*) 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 your health 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 receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *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 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps facilities and clinics online based on location, compare 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 even work with a single 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 via phone (toll-free) by calling 1-866-774-4626.

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 1-877-801-3507 (toll-free).

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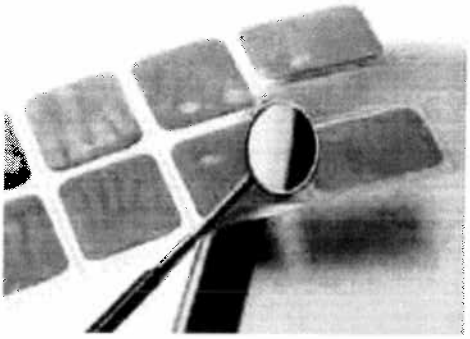
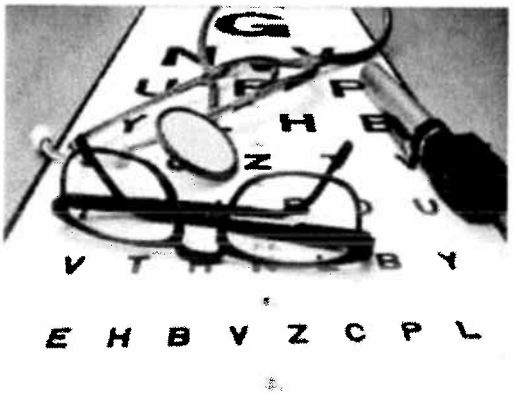
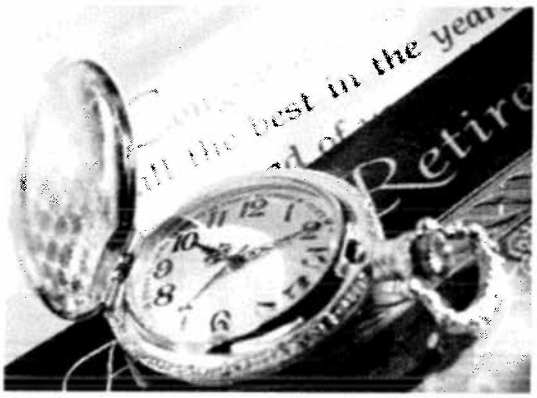
City of Dallas

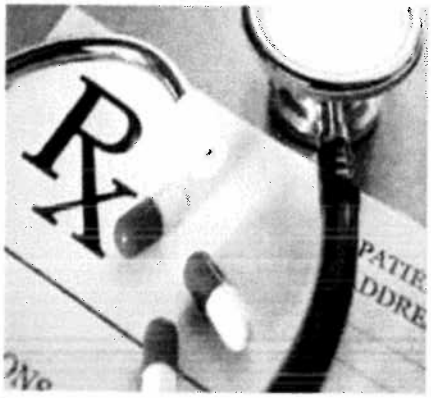
2013

Retiree Benefits & Enrollment Guide









Human Resources Department
Benefits Service Center

City of Dallas

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Summary of Benefits and Coverage

As a pre-65 retiree, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format to help you compare across options.

The SBC is available on the Web at: **http://dallascityhall.com/human_resources/benefits_retirees.html** and **www.cityofdallasbenefits.com**. A paper copy is also available, free of charge, by calling 1-888-752-9122.

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City of Dallas

Welcome to Benefits 2013!

Greetings, Retiree:

It is my pleasure to welcome you to the 2013 Open Enrollment. The City of Dallas provides an annual open enrollment period for retirees to review their benefits coverage and make new elections for the upcoming year.

Important things to know about this year's Open Enrollment:

- The Open Enrollment period for 2013 starts **October 1, 2012**, and ends **November 2, 2012**.
- Open Enrollment will be **passive**
  - ◊ You do not have to participate if you do not plan to make any changes to your current benefits plan (Medical, Dental and Vision)
- To make changes to your benefits elections, or to enroll for 2013, contact the Benefits Service Center at 1-888-752-9122 or visit the office at: Dallas City Hall, 1500 Marilla, Room 1DS.
- Pre-65 Retirees (UHC Medical: EPO 70/30 and EPO 75/25 HRA Plan)
  - ◊ Call the Benefits Service Center or visit the office, which is open Monday through Friday from 8:15 a.m. to 5:15 p.m.
- Post-65 Retirees (AARP and UHC Medicare Rx Plans)
  - ◊ For AARP (plans C, F and K), call 1-800-392-7537.
  - ◊ For UHC Medicare Rx, contact the Benefits Service Center at 1-888-752-9122.
  - ◊ For UnitedHealthcare Group Medicare Advantage (High or Low Option), call 1-800-950-9355
- Retirees (UHC Dental and Vision)
  - ◊ Contact the Benefits Service Center at Dallas City Hall, 1500 Marilla Street, Room 1DS
- If you need to add or delete dependents, please contact the Benefits Service Center at 1-888-752-9122. Make sure that you have the required documentation to add your dependents. You may also fax your documents to 1-888-202-5571; please include your name and a call-back number on each faxed page to process your request.

What's New for 2013?

New Vision Plan Option

The City of Dallas will offer two Vision plan options for 2013. There is the **Standard Plan**, which has not been altered from last year's plan, and the new **Buy-up Plan**. The Buy-up Plan will include the following additional lens options: polycarbonate lenses and standard anti-reflective coating. Polycarbonate lenses are impact-resistant lenses that are often utilized in children's eyewear. Standard anti-reflective coating will aid in glare reduction. There is also an out-of-network laser surgery benefit included with the Buy-up Plan.

New Open Enrollment Website

The City of Dallas has launched a new website to make the Open Enrollment process easier. You can get important information about benefits and the Open Enrollment process by visiting www.cityofdallasbenefits.com. This interactive portal offers you 24/7 access to benefits plan details, important notifications and tutorials to simplify the annual enrollment process. **This portal will only provide you with detailed benefits information; you cannot make benefits plan changes through this website.**

The Enrollment and Benefits Guide provides details about your benefit options. Reviewing the material contained in this guide will help you make informed decisions about your benefits for 2013. If you have any questions, refer to the vendor contact information section to access our service providers.

As always, I hope you will continue to be pleased with these programs and services as we endeavor to maintain a competitive benefits package for you and your family.

Sincerely,

Molly McCall
Human Resources Director

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Who is Eligible?

You may elect health coverage for you and your eligible dependents during the annual Open Enrollment period and through special enrollments as a result of a Qualifying Life Event. Eligible dependents include the following:

Type of Eligible Dependent	Required Documentation
Spouse (Person of opposite gender)	❖ Copy of Marriage License, Copy of Social Security Card, and Date of Birth If Common-Law Marriage applies, please provide the common-law form* and copies of documentation showing that you and your spouse have lived together for at least six months (provide two documents from list below). Examples include copies of: ◊ Lease or deed naming both partners ◊ Joint checking account statement ◊ Utility bills and/or credit accounts ◊ Will and/or life insurance policies
Domestic Partner (Person of same gender)	❖ Domestic Partner Form** and copies of documentation showing that you and your partner have lived together for at least six months (provide two documents from list below). Examples include copies of: ◊ Lease or deed naming both partners ◊ Joint checking account statement ◊ Utility bills and/or credit accounts ◊ Will and/or life insurance policies ❖ Copy of Social Security Card, and Date of Birth
Dependent Child: Child who is married or unmarried, under age 26 and is the biological child, legally adopted child or stepchild of you and/or your spouse, domestic partner or common-law spouse **Dependent Grandchild (Tax-dependent for current year):** A grandchild who is married or unmarried, under age 25 and is the biological grandchild of you and/or your spouse, domestic partner or common-law spouse	❖ Copy of Birth Certificate showing you as a parent, or ❖ Copy of Adoption Agreement, or ❖ Copy of court custody or guardianship documents, or ❖ Copy of the portion of the divorce decree showing the dependent, or ❖ Copy of Qualified Medical Court Support Order (QMCSO), and ❖ Copy of Social Security Card

*For the Common-Law Spouse Form, go to http://www.dallascounty.org/department/countyclerk/marriage-license.html.
**For the Domestic Partner Form, contact the Benefits Service Center at 1-888-752-9122.
Please note: Your dependents (spouse and children) cannot be covered on a plan if you are not covered.

Making Changes to Your Benefits During the Year (Outside the Open Enrollment Period)

In order for your benefits to be effective for the 2013 plan year (starting January 1, 2013), the Internal Revenue Service (IRS) requires that you make benefits elections during our annual Open Enrollment period. You may not change your benefits elections after Open Enrollment unless you experience a **Qualifying Life Event**, which may include:

- ❖ Marriage
- ❖ Divorce, Legal Separation or Annulment
- ❖ Birth or Adoption of an Eligible Child
- ❖ Change in your (or your spouse's) work status that affects benefits eligibility (e.g., change from full-time to part-time employment status)
- ❖ A change in your child's benefits eligibility
- ❖ A Qualified Medical Child Support Order

You must report your Qualifying Life Event to the Benefits Service Center **within 30 days** of that event with the required documentation to support your claim. If you fail to report your Qualifying Life Event within the required timeframe, you must wait until the next annual Open Enrollment to change your benefits elections.

If your dependent does not meet the current eligibility rules during the specified period, and/or you do not provide the required documentation, your dependent(s) will not be added to your benefits plan.

Reminders:

To enroll in a benefits plan or change your current plan, please remember:

1. The Open Enrollment period for 2013 starts **October 1, 2012**, and ends **November 2, 2012**.
2. You must report a Qualifying Life Event **within 30 days of that event** to change your benefits plan.
3. New retirees must enroll in a benefits plan within 30 days of their retirement date; otherwise, they forfeit coverage.

Non-Medicare Eligible Retiree Information

Enrollment Period:

October 1, 2012, through **November 2, 2012**

We encourage you to enroll early in this period to avoid the high volume of activity that occurs late in the enrollment period.

Enrollment Method and Instructions:

- Annual Enrollment will be **passive**, meaning that retirees who do not wish to make any benefit election changes do not have to participate; their current plan—consisting of Medical (Pre- and Post-65, Dental and Vision)—will roll over into the new plan year.
- If you would like to make changes to your existing plans or enroll in Colonial's voluntary benefits (Pre-65 only) for 2013, you must contact the Benefits Service Center (Monday through Friday, 8:15 a.m. to 5:15 p.m.) at 1-888-752-9122 to enroll during Open Enrollment.
- To update your dependent information for 2013, please contact the Benefits Service Center. Please have the required documentation available to add dependents. You may fax these documents to 1-888-202-5571. Please write your name and a call-back number on each faxed page.
- If you make benefit elections by calling the Benefits Service Center, it will be treated as an agreement to pay any required premium through pension check deductions. If you call and experience a long hold time, please leave a voicemail message with a daytime call-back number. Your call will be returned within two business days. Spanish-speaking assistance will be available.

Verification of Personal Information

To receive your identification cards promptly, make sure that your current mailing address is correct in the City's Human Resources Information System (HRIS). You may call the Benefits Service Center at 1-888-752-9122 to report an address change or other corrections.

How to Enroll for New Retirees after Open Enrollment

If you are planning to retire in 2013, call or make an appointment with the Benefits Service Center before your retirement to discuss retiree enrollment options and payroll deductions. You must enroll within 30 days after your date of retirement. You may be asked to pay the first two months' retiree health premiums in advance, depending on the date of retirement. Call the Benefits Service Center within 30 days of your retirement date to enroll. If you do not enroll within 30 days of your retirement date, the Benefits Service Center will presume that you have waived your retiree coverage with the City of Dallas. **You will not be eligible to participate in the City's health coverage in the future.**

If you enroll in retiree coverage, that coverage is effective on the first day of the month following your termination date with the City.

Upon retirement, all life insurance benefits will end unless you exercise your right to convert your coverage to an individual plan. Please contact the Benefits Service Center for additional information.

How to Enroll When Turning Age 65

When turning age 65, you should follow four steps:

1. **Notify the Benefits Service Center within 30 days of your birthday.**
   Within 30 days of reaching age 65, you and/or your covered spouses must report the change in age to the Benefits Service Center. If a rate adjustment is required as a result of your and/or your spouse turning age 65, the rate adjustment/reduction will be made the month following the birthday month of you and/or your spouse—provided the age change is reported to the Benefits Service Center before the first day of the month in which you and/or your spouse turn age 65. The effective rate before turning age 65 will be charged for the month you and/or your covered spouse turned age 65.

2. **Enrollment in Medicare Parts A and B**
   Three months before you turn age 65, contact your local Social Security Administration Office to enroll in Medicare Parts A and B.
   - Retirees and/or their covered spouses must enroll in Medicare Parts A and B at age 65 as a requirement of medical coverage through the City's benefit programs. Contact the Benefits Service Center if you or your spouse is not otherwise qualified for premium-free Medicare Part A coverage due to quarters earned through your employment or your spouse's employment.
   - Retirees must pay the full cost of the monthly premium for Medicare Part B. Medicare may charge a penalty to retirees who delay enrollment in Medicare Part B at the time of initial eligibility.
   - If a retiree waives coverage in a City sponsored health plan, the retiree will not be eligible for inclusion of Medicare Part A premium payments to be made on their behalf by the City of Dallas. Contact your local Social Security Administration office or go to www.ssa.gov to enroll and determine eligibility.

Enrollment in Medicare Supplement Plans

Once you have enrolled in Medicare Parts A and B, and become Medicare-eligible, you are no longer eligible to participate in the City's health plans. You must enroll in a medical supplement plan offered by the City. We suggest that you consider adding drug coverage since the Medicare Supplement Plan does not include prescription drug coverage. You have an option to either enroll in the City's Medicare Part D Plan or one of the Medicare Part D plans offered by various private insurance carriers. We strongly urge that you consider your personal needs before selecting any drug coverage option plan.

Continued on next page

How to Enroll When Turning Age 65
(continued)

4. **Enrollment in one of the Medicare Supplement plans is a two-step process.**
To enroll in Medicare Supplement plans C, F or K, contact the Medicare Supplement Enrollment Center at 1-800-392-7537, and request an enrollment kit. Please inform them that you are a City of Dallas retiree. Read and sign the application and mail it back to the Medicare supplement provider within 14 days. Your application will not be complete until it has been received by the Medicare supplement provider. They will provide an enrollment card once your application has been approved. Contact the Benefits Service Center to inform them that you are enrolling in the Medicare Supplement Plan C, F or K. If you wish to enroll in the City's Medicare Part D Plan, you must provide your Medicare claim number.

Medicare Eligible Retiree Information

How To Enroll

Enrollment Types:

- The post-65 benefits enrollment process will be passive, meaning you do not have to participate if you are satisfied with your current coverage (AARP Plans C, F and K ; Medicare Part D; Dental and Vision plans).
- If you are currently enrolled in the 75/25/HRA or the 70/30/3000 medical plans, you must contact your local Social Security Administration office to sign up for Medicare Parts A and B—that is, if you have not already completed this step. If you have already signed up, you must contact AARP to enroll in a supplemental plan (C, F or K), and you should contact the Benefits Service Center to enroll in Medicare Part D (prescription drugs). Post-65 members cannot be enrolled in the 75/25/HRA plan or the 70/30/3000 plan beginning January 1, 2013.

Enrollment Method and Instructions:

- Open Enrollment for 2013 will be passive (you do not participate if you are satisfied with your current benefits elections, including Medical, Dental and Vision).

Post-65 Retirees (AARP and UHC Medicare Rx Plans):

- For AARP (Plans C, F and K), call 1-800-449-4954.
- For UHC Medicare Rx, call the Benefits Service Center (1-888-752-9122) or visit the center at Dallas City Hall, Room 1DS.
- For UnitedHealthcare Group Medicare Advantage (High or Low Option), call 1-800-950-9355.

Retirees (UHC Dental and Vision)

- Call the Benefits Service Center (1-888-752-9122) or visit the center at 1500 Marilla Street, Room 1DS.

Dependent Information

To update your dependent information for 2013, please take one of the following steps:

1. Call the Benefits Service Center and speak with a customer service representative to remove a dependent (s).
2. To add a dependent, contact the Benefits Service Center; please provide documentation as listed on the Eligible Dependent chart (refer to page 5).
3. If you do not plan to make changes, no action is required. Please check your current information for accuracy.

- Elections made by calling the Benefits Service Center will be treated as an agreement to pay any required premium through pension check deductions.
- Should you experience long hold time when calling, leave a voicemail message with a daytime telephone number. A customer service representative will call you back within two business days. Spanish-speaking assistance is available.

Verification of Personal Information

To receive your identification cards promptly, make sure that your current mailing address is correct in the City's Human Resources Information System (HRIS). You may call the Benefits Service Center at 1-888-752-9122 to report an address change or other corrections.

Changing your Benefits During the Year (Qualified Status Change)

You can only change your benefit elections during the plan year if you undergo a qualified status change as defined by Internal Revenue Service guidelines. Your enrollment changes must be completed within 30 days of the qualifying event. If you fail to change your elections within 30 days of your event, you will have to wait until the next year's annual enrollment period to change your elections.

❑ **Reporting eligibility changes during the year**
You must report changes in dependent eligibility to the Benefits Service Center at 1-888-752-9122 within 30 days of the change (such as divorce, marriage or dependent child becoming ineligible). All status changes must be made within 30 days of the status change. If you are adding a spouse or dependent to your coverage, appropriate documentation will be required.

❑ **Special Note:** If you cancel your medical coverage as a retiree, you or your dependents may not re-enroll in any City-Sponsored medical plans in the future.

Duplicate Medical Coverage by Retiree

In the case where two city retirees are eligible for coverage, only one may enroll for dependent coverage. Both retirees cannot cover each other. In the case both retirees have eligible dependents, only one retiree can cover the dependents. Both retirees cannot cover their eligible dependents. If a retiree and his or her spouse are employed or retired from different employers, and are covered by the same insurance carrier, the health plan will pay only up to the allowable.

Important Disclaimers

Paying for Medical Coverage
Medical contributions are paid on a post-tax basis for all retirees. Your annual cost of medical coverage depends on the benefit option you choose and the level of coverage you need. Contribution costs for 2013 can be found in this benefits and enrollment guide.

- ❑ Contributions shall be paid by pension check deduction by all Members who receive pension checks in sufficient amount to permit deduction for the contributions. For each regular pension check during the plan year a member will pay the monthly rates indicated in Article IV of the Master Plan Document. If for any reason a Member's pension check is not reduced by the amount of a contribution or does not receive pension check with a sufficient amount to permit deduction for the contributions, contributions must be paid by check or money order on a monthly basis.
- ❑ For each regular pension check during the plan year a member will pay the monthly rates indicated in this enrollment guide.
- ❑ A grace period of thirty days shall be allowed for the payment of each contribution paid directly by the member. If any contribution is not paid within the grace period, the coverage shall terminate on the last date for which contributions are paid.
- ❑ Dropping Coverage: If the notice for dropping coverage is received prior to the 15th of the month, deductions will not be taken and coverage will end the last day of the previous month. If the notice for dropping dependent coverage is received after the 15th of the month, deductions and coverage will be discontinued the first day of the following month.

Benefits Information for Certain Medicare-eligible Retirees

Medical benefit options
For certain Medicare-eligible retirees, the City will continue to offer its Medicare Supplements, Medicare HMO and Medicare Part D benefit options. If you have any questions, please contact the benefits provider. In the next few months, you will receive a letter from your Medicare Part D provider to alert you of the following information.

- ❑ Annual Notice of Change (ANOC), which will include:
  - ◊ 2013 Formulary List
  - ◊ Summary of Benefits
  - ◊ Mail-order information
  - ◊ Pharmacy Directory
- ❑ Explanation of Benefits (EOB)
- ❑ Explanation of Coverage (EOC)

The documents listed above will require no action on your part because you are already enrolled. However, if you receive a Late Enrollment Penalty Letter, you are required to complete and return as instructed in the letter. For help in completing this letter, please call the City of Dallas Benefits Service Center at 1-888-752-9122.

Retiree EPO 75/25 HRA Medical Plan Comparison Chart (In-Network Benefits Only)		
Total Deductible	$2500 (single)	$2500 (single)
HRA Allocation (City $$)	$1000 (single)	$700 (single)
Deductible (Your $$)	$1500 (single)	$1800 (single)
Total Deductible	$5000 (with dep(s)	$5000 (with dep(s)
HRA Allocation (City $$)	$2000 (with dep(s)	$1700 (with dep(s)
Deductible (Your $$)	$3000 (with dep(s)	$3300 (with dep(s)
Coinsurance	Member pays 25% Plan pays 75%	Member pays 25% Plan pays 75%
Preventive Services (See SPD for Injections)	Plan pays 100% (in-network only) doesn't reduce HRA	Plan pays 100% (in-network only) doesn't reduce HRA
Outpatient Services	Plan pays 75% after deductible	Plan pays 75% after deductible
Inpatient Services	Plan pays 75% after deductible	Plan pays 75% after deductible
ER Services at hospital (See SPD for Ambulance services)	Plan pays 75% after deductible	Plan pays 75% after deductible
Specialist Services & Urgent Care Services	Plan pays 75% after deductible	Plan pays 75% after deductible
Out-of-Pocket Max	$6000 (single) $12000 (with deps)	$6000 (single) $12000 (with deps)
Rx Coverage (CVS/Caremark):		
Deductible	Same as (Your $$) Deductible above	Same as (Your $$) Deductible above
Generic (31 days)	10%	10%
Preferred (31 days)	25%	25%
Non-Preferred (31 days)	40%	40%

Retiree EPO 75/25 HRA Medical Plan Monthly Rates (Non-Tobacco User)		
Retiree Rates	HEALTH ASSESSMENT COMPLETED	HEALTH ASSESSMENT NOT COMPLETED
Retiree Only	$484	$494*
Retiree + Spouse	$1,141	$1,151*
Retiree + Child(ren)	$787	$797*
Retiree + Family	$1,414	$1,424*
Retiree's Spouse Only	$760	$770*
Retiree's Spouse + Child(ren)	$1,033	$1,043*

*There is a $10 monthly surcharge for non-tobacco users who did not complete the online health assessment.

Retiree EPO 75/25 HRA Medical Plan Monthly Rates (Tobacco User)^		
Retiree Rates	HEALTH ASSESSMENT COMPLETED	HEALTH ASSESSMENT NOT COMPLETED
Retiree Only	$504	$514*
Retiree + Spouse	$1,161	$1,171*
Retiree + Child(ren)	$807	$817*
Retiree + Family	$1,434	$1,444*
Retiree's Spouse Only	$780	$790*
Retiree's Spouse + Child(ren)	$1,053	$1,063*

^Tobacco users pay a higher monthly premium rate for their medical benefits.
*There is a $10 monthly surcharge for non-tobacco users who did not complete the online health assessment.

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Retiree EPO 70/30 Plan Comparison Chart (In-Network benefits only)	
Total Deductible	$3000 (single) $9000 (with dep(s)
HRA Allocation (City $$)	N/A
Deductible (Your $$)	Same as Total Deductible
Coinsurance	Member pays 30% Plan pays 70%
Preventive Services (See SPD for Injections)	Plan pays 100%
Outpatient Services	Plan pays 70% after deductible
Inpatient Services	Plan pays 70% after deductible
ER Services at hospital **(See SPD for Ambulance services)**	$100 Copay plus plan pays 70% after deductible
Specialist Services & Urgent Care Services	Plan pays 70% after deductible
Out-of-Pocket Max	$7500 (single) $15000 (with dep(s)
Rx Coverage (CVS/Caremark):	
Deductible	$150/person
Generic (31 days)	10% or $10 minimum
Preferred (31 days)	25% or $25 minimum
Non-Preferred (31 days)	40% or $40 minimum
Out-of-Pocket Max	$2500/person

Retiree EPO 70/30 Plan Monthly Rates (Non-Tobacco User)		
Retiree Rates	HEALTH ASSESSMENT COMPLETED	HEALTH ASSESSMENT NOT COMPLETED
Retiree Only	$384	$394
Retiree + Spouse	$1,003	$1,013
Retiree + Child(ren)	$625	$635
Retiree + Family	$1,236	$1,246
Spouse of Retiree Only	$722	$732
Spouse of Retiree + Child(ren)	$963	$973
*There is a $10 monthly surcharge for non-tobacco users who did not complete the online health assessment.		

Retiree EPO 70/30 Plan Monthly Rates (Tobacco User)^		
Retiree Rates	HEALTH ASSESSMENT COMPLETED	HEALTH ASSESSMENT NOT COMPLETED
Retiree Only	$404	$414
Retiree + Spouse	$1023	$1,033
Retiree + Child(ren)	$645	$655
Retiree + Family	$1,256	$1,266
Spouse of Retiree Only	$742	$754
Spouse of Retiree + Child(ren)	$983	$993
^Tobacco users pay a higher monthly premium rate for their medical benefits. *There is a $10 monthly surcharge for non-tobacco users who did not complete the online health assessment.		

CVS Caremark Prescription Benefit Program

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CVS Caremark administers your prescription benefit, which is designed to provide you quality pharmacy care that will help you save money. The information provided below is a brief summary of your prescription benefits. CVS Caremark and the City of Dallas are confident you will find value with your prescription benefit program.

Your plan is based on a combined deductible of medical and prescription claims. The deductible is the total "out-of-pocket" spending required by you before prescription benefits are paid. You annual deductible is for an individual or a family. Until this deductible amount is met, you will pay 100 percent for your prescriptions.

Find more information about your pharmacy program at www.caremark.com. Call 1-855-465-0023 to obtain a copy of the new prescription drug list (PDL), a mail order form for new mail order prescriptions and other important information including the Specialty Pharmacy Program.

	75/25 HRA Plan		70/30 Plan	
	CVS Caremark Retail Pharmacy Network For short-term medications (up to a 31-day supply)	**CVS Caremark Mail Service Pharmacy** For long-term medications (up to a 90-day supply)	**CVS Caremark Retail Pharmacy Network** For short-term medications (up to a 31-day supply)	**CVS Caremark Mail Service Pharmacy** For long-term medications (up to a 90-day supply)
Generic Medications	10% for a generic prescription	10% for a generic prescription	10% ($10 min) for a generic prescription	10% ($10 min) for a generic prescription
Preferred Brand-Name Medications	25% for a preferred, brand-name prescription	25% for a preferred, brand-name prescription	25% ($25 min) for a preferred, brand-name prescription	25% ($25 min) for a preferred, brand-name prescription
Non-Preferred, Brand-Name Medications	40% for a non-preferred, brand-name prescription	40% for a non-preferred, brand-name prescription	40% ($40 min) for a non-preferred, brand-name prescription	40% ($40 min) for a non-preferred, brand-name prescription
Refill Limit	None	None	None	None
Annual Deductible	$2,500 (Individual); $5,000 (Family)		$150 (Individual)	
Maximum Out-of-Pocket	$6,000 (Individual); $12,000 (Family)		$2,500 (Individual)	
Web Services	Register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your prescription card ready.			
Customer Care	Visit www.caremark.com or call toll-free at 1-855-465-0023.			

Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with any balance paid by a Plan.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

CVS CAREMARK

Prorated HRA Funds
(Based on the month of enrollment)

Month	Retiree Only	Retiree & Dependents
January	$700.00	$1,700.00
February	$641.67	$1,558.33
March	$583.34	$1,416.66
April	$525.01	$1,274.99
May	$466.68	$1,133.32
June	$408.35	$991.65
July	$350.02	$849.98
August	$291.69	$708.31
September	$233.36	$566.64
October	$175.03	$424.97
November	$116.70	$283.30
December	$58.37	$141.63

Onsite Health Clinic Medical Plan Services

Concentra TotalCare Health and Wellness Center is the on-site medical clinic located at Dallas City Hall. The center offers select preventive and diagnostic services to pre-65 retirees and dependents (age 5 and older) covered by the City's health plan at no cost.

Onsite Clinic Services for Retirees Enrolled in City of Dallas Medical Plans

Visit Description	EPO 75/25 HRA Plan	EPO 70/30 Plan
Preventive Care Services ❑ Services provided at onsite clinic ❑ Lab services that are sent out to LabCorp will be processed according to your medical plan benefits.	❑ No cost to retirees or dependents ❑ Paid at 100%	❑ No cost to the retiree or dependents ❑ Paid at 100%
Injury or Illness Care: Diagnostic Services ❑ Service provided at onsite clinic ❑ Lab services that are sent out to LabCorp will be processed according to your medical plan benefits	❑ No cost to retirees or dependents ❑ Services are subject to 25% coinsurance after $2,500 deductible is met; HRA funds will be used if still available	❑ No cost to retirees or dependents ❑ Services are subject to 30% coinsurance after $3,000 deductible is met

Concentra TotalCare Health and Wellness Center | 1500 Marilla, Room 1CS, Dallas, TX 75201
Phone: 214-671-9140 | Fax: 214-749-0412 | Hours: Monday through Friday, 7:30 a.m. to 5:30 p.m.

Concentra®
treated right

Dental Plan Overview

United Healthcare is our provider for dental offerings for 2013. Your options include:

- Dental EPO, which allows you to select the provider of your choice
- Dental HMO, which provides in-network benefits only while having a co-pay schedule
- Dental EPO, which allows you to select the provider of your choice while having a co-pay schedule

Plan Features	UHC PPO		UHC DHMO	UHC EPO
	In-Network	Out-of-Network	In-Network Only	
Calendar Year Deductibles • Individual • Family	$50 $150		$0 $0	$50 $150
Maximum • Calendar Year • Orthodontic Lifetime	$1,000 per person N/A		$0 ********	$1,250 $1,500
Visits and Exams • Office visit • Oral Exam • X-rays	You pay 0%	You pay any charges in excess of Allowed Amount*	Office visit: $5 Oral exam: $0 X-rays: $0	Copays vary by service according to Patient Charge Schedule*
Basic Services • Fillings • General Services • Space Maintainers	You pay 0%	You pay 20% and any charges In excess of Allowed Amount*	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*
Major Services • Crowns • Dentures/Bridges	You pay 50%	You pay 50% and any charges in excess of Allowed Amount*	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*
Orthodontic Services	Not Covered	Not Covered	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*

**The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographic area in which the expenses are incurred.

Monthly Dental Plan Rates			
Coverage Level	Dental PPO	Dental HMO	Dental EPO
Retiree Only	$24.13	$7.76	$18.02
Retiree + Spouse	$48.27	$14.29	$33.15
Retiree + Child(ren)	$49.23	$14.36	$33.32
Retiree + Family	$73.39	$20.20	$46.86

Vision Plan Overview

New Vision Plan Option

The City of Dallas will offer two Vision plan options for 2013. There is the Standard Plan, which has not been altered from last year's plan, and the new Buy-up Plan. The Buy-up Plan will include the following additional lens options: polycarbonate lenses and standard anti-reflective coating. Polycarbonate lenses are impact-resistant lenses that are often utilized in children's eyewear. Standard anti-reflective coating will aid in glare reduction. There is also an out-of-network laser surgery benefit included with the Buy-up Plan.

Monthly Vision Plan Rates		
Coverage Level	Standard Plan	Buy-up Plan
Retiree Only	$4.79	$5.76
Retiree + Spouse	$8.75	$10.52
Retiree + Child(ren)	$9.19	$11.04
Retiree + Family	$14.14	$17.01

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Vision Plan Overview *(continued)*

Benefit/Service	Standard Plan		Buy-up Plan	
	UHC Network Provider	Out-of-Network Reimbursement[1]	UHC Network Provider	Out-of-Network Reimbursement[1]
Comprehensive Exam (every 12 months)	$10 copay	up to $40.00	$10 copay	up to $40.00
Materials	$25 copay	See spectacle lenses and frame benefit below	$25 copay	See spectacle lenses and frame benefit below
Spectacle Lenses* (every 12 months) Standard Plan: • Standard Scratch-Resistant Coating Buy-up Plan: • Standard Scratch-Resistant Coating • Polycarbonate Lenses • Standard Anti-Reflective Coating	$25 copay	Single Vision up to $40.00 Bifocal up to $60.00 Trifocal up to $80.00 Lenticular up to $80.00	$25 copay	Single Vision up to $40.00 Bifocal up to $60.00 Trifocal up to $80.00 Lenticular up to $80.00
Frames (every 24 months)	$130.00 retail frame allowance	Up to $45.00	$130.00 retail frame allowance	Up to $45.00
Contact Lenses (every 12 months)** • Fitting/evaluation • Contacts • Two follow-up visits (after $25 copay).	Covered-in-full selection or $105.00 allowance	Elective up to $105.00 Necessary up to $210.00	Covered-in-full selection or $105.00 allowance	Elective up to $105.00 Necessary up to $210.00
Laser Vision* **	N/A	N/A	N/A	Lifetime Max Reimbursement of $500

[1]Out-of-Network Reimbursements: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: UHC Vision, ATTN: Claims Dept., P. O. Box 30978, Salt Lake City, UT 84130.

Important to Remember

*Benefits available every 12 to 24 months (depending on the benefit frequency), based on last date of service.

**Your $105 Contact Lens allowance is applied to the fitting/evaluation fees and the purchase of the contact lenses. For example, if the fitting/evaluation fee is $30, you will have $75 toward the purchase of contact lenses. The allowance ma be separated at some retail chain locations between the examining physician and the optical store. If you chose disposable contacts, you may receive up to four boxes of disposable contacts (depending on prescription). Toric, gas permeable and bifocal contacts are all examples that are outside our covered-in-full selection.

***UHC has partnered with the Laser Vision Network of America (LVNA) to provide members with access to discounted laser correction providers (877-25-SIGHT)

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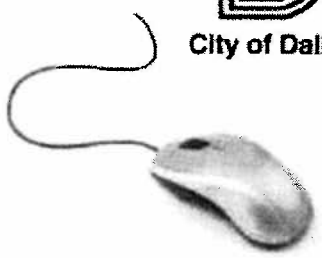
City of Dallas

Learn more about your benefits plan at myuhc.com.



The tools and information at myuhc.com are both practical and personalized so you can get the most out of your benefits. Register at myuhc.com and connect to current information about your benefits plan and health care interests.

UnitedHealthcare

It's all at your fingertips online at www.myuhc.com:

1. **Compare costs for different health plans.**
   (Select Plan Cost Estimator located under Links & Tools)
2. **Ask health care professionals.**
   Select Live Nurse Chat on the home page to get one-on-one advice seven days a week online.
3. **Organize your medical claims online.**
   View processed claims, remaining balances for deductibles and out-of-pocket expenses via your Health Statements.
   Arrange automatic payments, direct deposits and more.
4. **Get information about hospitals and physicians.**
   Find in-network doctors based on practice.
5. **Learn more about your coverage.**
   Learn what services are covered by your medical plan.
6. **Organize and store all of your health data in one convenient, confidential place.**
   Record your family medical history and track your health progress.
   Download your personal health summary.
7. **Improve your health habits.**
   Participate in health coaching programs that help set goals to achieve health objectives.
8. **Learn about health conditions and treatment options.**
   (Select Health & Wellness>Conditions AtoZ)
9. **Request a medical ID card.**
   Print a temporary ID card or request a replacement card.

AARP Supplement Plan Rates			
Tier	Plan C	Plan F	Plan K
Retiree Only	$135	$135	$80
Retiree + Spouse	$300	$275	$184
Spouse Only	$205	$200	$104

United Medicare Rx		
Tier	Part D^ (Option 1)	Part D^^ (Option 2)
Retiree Only	$153	$89
Retiree + Spouse	$310	$228
Spouse Only	$155	$139

^Option 1 has full gap coverage for Brand name and Generic drugs.
^^Option 2 has full gap coverage for Generic drugs only; donut hole would apply only to Brand name drugs.

UHC Group Medicare Advantage		
Tier	High Option	Low Option
Retiree Only	$162	$114
Retiree + Spouse	$421	$284
Spouse Only	$259	$160

Medicare Supplemental Plans
Monthly Cost for Texas Residents
Rates are for Texas residents only. Rates for other states will vary. All rates subject to change during 2013. Actual rates, which may contain discounts or surcharges, are subject to change and will be provided in the enrollment kits provided to prospective insured. Retirees also will pay Medicare Part B monthly premiums.

^Medicare Part D Prescription-only Plan
No medical included. Purchase with or without Medicare Supplement plan. This plan **cannot** be purchased with the PPO plans.

Plan C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as a hospital inpatient and ends after you have been discharged and have not received skilled care in any other facility for 60 consecutive days.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132*	$1,132 (Part A Deductible)	$0
61st thru 90th day 91st day and after:	All but $283/day*	$283/day	$0
• While using 60 lifetime reserve days	All but $566/day	$566/day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare-eligible expenses	$00**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $141.50/day	Up to $141.50/day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*The rates illustrated in this table may not be accurate. Please contact AARP to confirm.

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

***Once you have been billed $141.50 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
MEDICAL EXPENSES (IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT), such as physician services; inpatient and outpatient medical and surgical services and supplies; physical and speech therapy; diagnostic tests; and durable medical equipment			
First $141.50 of Medicare-approved amounts*** **Remainder of Medicare-approved amounts**	$0 Generally 80%	$141.50 (Part B Deductible) Generally 20%	$0 $0
PART B EXCESS CHARGES (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD—First three pints Next $141.50 of Medicare-approved amounts*** Remainder of Medicare-approved amounts	$0 $0 80%	All costs $141.50 (Part B Deductible) 20%	$0 $0 $0
PARTS A and B			
HOME HEALTH CARE—MEDICARE-APPROVED SERVICES			
⊙ Medically necessary skilled care services and medical supplies	100%	$0	$0
⊙ Durable medical equipment: • First $141.50 of Medicare-approved amounts*** • Remainder of Medicare-approved amounts	$0 80%	$141.50 (Part B Deductible) 20%	$0 $0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL—NOT COVERED BY MEDICARE (Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.)			
First $250 each calendar year Remainder of Charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 and amounts over the $50,000 lifetime maximum

Medical benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Plan Benefit Tables: Plan F

Medicare Part A: Hospital Service per Benefit Period[1]

Service		Medicare Pays	Plan F Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies	First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
	Days 61-90	All but $283/day	$283/day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $566/day	$566/day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare-eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21-100	All but $141.50/ day	Up to $141.50/ day	$0
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/co-insurance	$0

Notes:

[1] A benefit period begins on the first day you receive service as a hospital inpatient, and ends after you have been discharged and received no skilled care in any other facility for 60 consecutive days.

[2] **NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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Plan Benefit Tables: Plan F (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan F Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies; physical and speech therapy; diagnostic tests; and durable medical equipment.	First $162 of Medicare-approved amounts[3]	$0	$162 (Part B Deductible)	$0
	Remainder of Medicare-approved amounts	Generally 80%	Generally 80%	$0
Part B Excess Charges Above Medicare-approved amounts		$0	100%	$0
Blood	First 3 pints	$0	All costs	$0
	Next $162 of Medicare-approved amounts[3]	$0	$162 (Part B Deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

Service		Medicare Pays	Plan F Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment Medicare-approved services	First $162 of Medicare-approved amounts	$0	$162 (Part B Deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not Covered by Medicare

Service		Medicare Pays	Plan F Pays	You Pay
Foreign Travel NOT COVERED BY MEDICARE: Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.	**First $250 each calendar year**	**$0**	**$0**	**$250**
	Remainder of charges	**$0**	**80% to a lifetime maximum benefit of** $50,000	**20% and amounts over the $50,000 lifetime maximum**

Notes:

[3] Once you have been billed $162 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan K

Medicare Part A: Hospital Service per Benefit Period[1]

Service		Medicare Pays	Plan K Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies	First 60 days	All but $1,132	$566 (50% of Part A Deductible)	$566 (50% of Part A Deductible) ❖
	Days 61-90	All but $283/day	$283/day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $566/day	$566/day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare-eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21-100	All but $141.50/ day	Up to $70.75/ day	Up to $70.75/day ❖
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	50%	50%❖
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care	50% of co-payment/co-insurance	50% of Medicare co-payment/co-insurance❖

Notes:

[1] A benefit period begins on the first day you receive service as a hospital inpatient, and ends after you have been discharged and received no skilled care in any other facility for 60 consecutive days.

[2] **NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

[3] You will pay half of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $4,640 each calendar year. The amounts that count toward your annual limit are noted with diamonds(❖) in the chart above. Once you reach the annual limit, the plan pays 100 percent of the Medicare co-payment and co-insurance fees for the remainder of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"); you will be responsible for paying the difference of the amount charged by your provider and the amount paid by Medicare for the item or service.

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Plan Benefit Tables: Plan K (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan K Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies; physical and speech therapy; diagnostic tests; and durable medical equipment.	First $162 of Medicare-approved amounts[5]	$0	$0	$162 (Part B Deductible)[5]◆
	Preventive Benefits for Medicare-covered Services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Part B Excess Charges Above Medicare-approved amounts		$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $4,640)[4]
Blood	First 3 pints	$0	50%	50%◆
	Next $162 of Medicare-approved amounts[3]	$0	$0	$162 (Part B Deductible)[5]◆
	Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

Service		Medicare Pays	Plan K Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment Medicare-approved services	First $162 of Medicare-approved amounts[6]	$0	$0	$162 (Part B Deductible)◆
	Remainder of Medicare-approved amounts	80%	10%	10%◆

Notes:

[4] This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $4,640 per calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"); you will be responsible for paying the difference of the amount charged by your provider and the amount paid by Medicare for the item or service.

[5] Once you have been billed $162 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

[6] Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

United Medicare Rx™ - Option I

United MedicareRx Enhance Medicare Part D Prescription Drug Plan

The City of Dallas is pleased to be able to provide with you a Medicare Part D prescription drug plan called United MedicareRx, which is offered through UnitedHealthcare Insurance Company. Coverage will be effective beginning January 1, 2013. With United MedicareRx, you have prescription drug insurance you can count on to protect you and meet your prescription drug needs today and in the future.

Here are some of the key features of this prescription drug coverage:

- ❑ **No annual deductible or out-of-pocket maximum** – start saving with the first prescription you fill
- ❑ Predictable and **affordable** flat **co-pays** as low as $10.00 for generic drugs
- ❑ No need to worry about the coverage gap or "doughnut hole"; you are fully covered
- ❑ A **formulary** that includes 100% of the drugs covered by Medicare Part D
- ❑ **National pharmacy network** with more than 65,000 convenient locations so you are covered at home or while you are traveling across the United States.

Part D Benefits

- ❑ The United MedicareRx plan has three different levels of co-pays for a 31-day supply of prescription drugs.
- ❑ The United MedicareRx plan formulary covers 100 percent of the drugs covered by Medicare Part D.
- ❑ Effective on or after October 1, 2012.
- ❑ A complete formulary listing will be available on request or online at www.UnitedMedicareRx.com.

Your Co-pays for the three tiers are:

Contracted retail Pharmacy Co-pay Levels	Type of Medication
Tier 1 - $10	Most generic drugs, lowest co-pay
Tier 2 - $25	Preferred brand-name drugs, medium co-pay
Tier 3/Specialty - $50	Non-preferred or unique drugs, higher co-pay

Summary of Prescription Drug Benefits (Effective January 1, 2013, through December 31, 2013)		
Drug Benefit	**2013 Out-of-Pocket Costs**	**You Pay**
Outpatient Prescription Drugs	$0 - $4,750 (a) in Enrollee/Plan Out-of-Pocket	**Retail** $10 co-pay for a one month (31 day) supply of **Tier 1** drugs $25 co-pay for a one month (31 day) supply of **Tier 2** drugs $50 co-pay for a one month (31 day) supply of **Tier 3** or **Specialty Tier** drugs **Mail Services** $20 co-pay for a three month (90 day) supply of Tier 1 drugs you get through Our contracted Mail Service Pharmacy $50 co-pay for a three month (90 day) supply of Tier 2 drugs you get through our contracted Mail Service Pharmacy $100 co-pay for a three month (90 day) supply of Tier 3 drugs you get through our contracted Mail Service Pharmacy
Catastrophic Care	Over $4,750 (a) in Enrollee Out-of-Pocket	You pay the greater of $2.65 or 5 percent co-insurance for generic or a preferred brand name drug that is a multi-source drug, and $6.60 for all other drugs, or 5 percent once your total out-of-pocket costs reach $4,750

United Medicare Rx™ - Option II

United MedicareRx Enhance Medicare Part D Prescription Drug Plan

The City of Dallas is pleased to be able to provide you a Medicare Part D prescription drug plan called United MedicareRx, which is offered through UnitedHealthcare Insurance Company. Coverage will be effective beginning January 1, 2013. With United MedicareRx, you have prescription drug insurance you can count on to protect you and meet your prescription drug needs today and in the future.

Here are some of the key features of this prescription drug coverage:

- ❑ **No annual deductible or out-of-pocket maximum** – start saving with the first prescription you fill
- ❑ Predictable and **affordable** flat **co-pays** until you reach the gap.
- ❑ **Coverage Gap (donut hole):** Generic drugs covered at co-pays in the gap. Medicare Part D covered brand medications in the gap at 50% co-insurance. A **formulary** that includes 100% of the drugs covered by Medicare Part D
- ❑ **National pharmacy network** with more than 66,000 convenient locations so you are covered at home or while you are traveling across the United States.

Part D Benefits
The United MedicareRx plan has three different levels of co-pays for a 31-day supply of prescription drugs. The United MedicareRx plan formulary covers 100 percent of the drugs covered by Medicare Part D.
Effective on or after October 1, 2012.
A complete formulary listing will be available on request or online at www.UnitedMedicareRx.com.

Your co-pays prior to reaching the gap for the three tiers are:

Contracted Retail Pharmacy Co-pay Levels	Type of Medication
Tier 1 - $10	Most generic drugs, lowest co-pay
Tier 2 - $25	Preferred brand-name drugs, medium co-pay
Tier 3/Specialty - $50	Non-preferred or unique drugs, higher co-pay

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United Medicare Rx™ - Option II (continued)

Summary of Prescription Drug Benefits (Effective January 1, 2013, through December 31, 2013)		
Drug Benefit	**2013 Out-of-Pocket Costs**	**You Pay**
Outpatient Prescription Drugs	$0 - $2,970 (a) in Enrollee/Plan Out-of-Pocket. (Until you reach the coverage gap/donut hole)	**Retail** $10 co-pay for a one month (31 day) supply of **Tier 1** drugs $25 co-pay for a one month (31 day) supply of **Tier 2** drugs $50 co-pay for a one month (31 day) supply of **Tier 3** or **Specialty Tier** drugs **Mail Services** $20 co-pay for a three month (90 day) supply of Tier 1 drugs you get through our contracted Mail Service Pharmacy $50 co-pay for a three month (90 day) supply of Tier 2 drugs you get through our contracted Mail Service Pharmacy $100 co-pay for a three month (90 day) supply of Tier 31 drugs you get through our contracted Mail Service Pharmacy
Coverage Gap (Donut Hole)	$2,970 - $4,750 (a) in Enrollee/Plan/ Manufacturer Out of Pocket Expense	**Retail** $10 co-pay for a one month (31 day) supply of **generic drugs** 50% co-insurance for a one month (31 day) supply of Medicare Coverage Brand drugs. (Tier 2 and 3) **Mail Services** $20 co-pay for a three month (90 day) supply of **generic drugs** you get through our contracted Mail Service Pharmacy 50% co-insurance for a three month (90 day) supply of Medicare coverage brand drugs. (Tier 2 and 3)
Catastrophic Care	Over $4,750 (a) in Enrollee Out-of-Pocket	You pay the greater of $2.65 or 5 percent co-insurance for generic or a preferred brand name drug that is a multi-source drug, and $6.60 for all other drugs, or 5 percent once your total out-of-pocket costs reach $4,750

UnitedHealthcare® Group Medicare Advantage

UnitedHealthcare® Group Medicare Advantage - Low Option HMO Plan 18410	
Benefits and Coverage	**Member's Costs**
Physician Services/Basic Health Services Consultation, diagnosis, and treatment Primary Care Physician Specialist	 $15 co-payment per office visit $25 co-payment per office visit
Annual Physical Examination Includes Pap smears	Covered in full
Immunizations Flu shots, pneumococcal vaccine and Hepatitis B injections All other Medicare-approved immunizations	 Covered in full Covered in full
Hospitalization	$500 co-payment per admission*
Non-network/out-of-Area Urgent Care	$25 co-payment
Ambulance Services Medically necessary ambulance transport	$50 co-payment
Outpatient Surgical Services Certified Ambulatory Surgical Center Outpatient Hospital Facility	 $250 co-payment $250 co-payment
Outpatient Mental Health Care/ Outpatient Substance Abuse Treatment	$25 co-payment
Inpatient Psychiatric Care/ Inpatient Substance Abuse Treatment	$500 co-payment per admission, up to 190 Days lifetime maximum in a psychiatric hospital
Emergency Services You may go to any emergency room if you reasonably believe you need emergency care	Covered Worldwide $50 co-payment, waived if admitted to hospital Within 24 hours for the same condition
Prescription Drugs – Retail (up to 30 day-supply)	$15 generic; $25 brand-name; $40 non-formulary
Prescription Drugs – Mail Order (90 day-supply)	$30 generic; $50 brand-name; $80 non-formulary
Renal Dialysis	$25 at network facility or Medicare Facility
Radiation Therapy	$25 co-payment
Radiology Services Standard X-ray films Specialized scanning and imaging procedures CT, SPECT, PET, MRI–with or without contrast media	 $15 Primary Care Physician $25 Specialist co-payment, per office visit
Skilled Nursing Facility Care	Covered $0/day Days 1-20, $50/day Days 21-100 up to 100 days per benefit period** in a Medicare-certified Skilled Nursing Facility
Vision Care Examination for eyeglasses (Refraction)	$25 for Medicare covered eye exams, per visit
Hearing Services Routine hearing examination	$25 for Medicare covered hearing exams, per visit
Chiropractic Services	$25 co-payment, per office visit; Medicare Benefit only

*Inpatient Hospital co-payments are not charged on a per admission or daily basis. **Original Medicare hospital benefit periods do not apply.** For Inpatient Hospital, you are covered for an unlimited number of days as long as they hospital stay is medically necessary and authorized by UnitedHealthcare or contracting providers. When you are admitted to an Inpatient Hospital and then subsequently transferred to another Inpatient Hospital, you pay the co-payment charged for the first hospital admission. You do not pay a co-payment for the second hospital admission; the co-payment is waived.

**A benefit period begins the day you go to a hospital. The benefit period ends when you have not received hospital or skilled care (in a SNF) for 60 consecutive days. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the skilled nursing facility care co-payment, if applicable, for each benefit period. There is no limit to the number of benefit periods you can have.

UnitedHealthcare® Group Medicare Advantage

UnitedHealthcare® Group Medicare Advantage - High Option HMO Plan 18409	
Benefits and Coverage	**Member's Cost**
Physician Services/Basic Health Services Consultation, Diagnosis and Treatment Primary Care Physician Specialist	 $10 co-payment per office visit $20 co-payment per office visit
Annual Physical Examination Includes Pap smears	$0 Primary Care Physician
Immunizations Flu Shots, Pneumococcal Vaccine and Hepatitis B Injections All other Medicare-approved Immunizations	 Covered in Full Covered in Full
Hospitalization	$250 co-payment per admission*
Non-network/Out-of-Area Urgent Care	$25 co-payment
Ambulance Services Medically Necessary Ambulance Transport	$50 co-payment
Outpatient Surgical Services Certified Ambulatory Surgical Center Outpatient Hospital Facility	 $125 co-payment $125 co-payment
Outpatient Mental Health Care/Outpatient Substance Abuse Treatment	$20 co-payment
Inpatient Psychiatric Care/ Inpatient Substance Abuse Treatment	$250 co-payment per admission, up to 190 days lifetime maximum in a psychiatric hospital
Emergency Services You may go to any emergency room if you reasonably believe you need emergency care	Covered worldwide $50 co-payment, waived if admitted to hospital within 24 hours for the same condition
Prescription Drugs-Retail (up to 30-day supply)	$10 generic; $20 brand name; $40 non-formulary
Prescription Drugs-Mail Order (90-day supply)	$20 generic; $40 brand name; $80 non-formulary
Renal Dialysis	$20 at network facility or Medicare facility
Radiation Therapy	$20 co-payment
Radiology Services Standard X-ray Films Specialized Scanning & Imaging Procedures CT, SPECT, PET, MRI (with or without contrast media)	Covered in Full
Skilled Nursing Facility Care	Covered $0/day for Days 1-20; $50/day for Days 21-100; up to 100 days per benefit period** in a Medicare-certified Skilled Nursing Facility
Vision Care Examination for Eyeglasses (Refraction)	$10 per visit for Medicare-covered eye exams $20 Specialist co-payment per office visit
Hearing Services Routine Hearing Examination	Medicare diagnostic hearing examinations—$20 Specialist co-payment per office visit
Chiropractic Services	$10 co-payment per office visit; Medicare benefit only

*Inpatient Hospital co-payments are not charged on a per-admission or daily basis. **Original Medicare hospital benefit periods do not apply**. For Inpatient Hospital, you are covered for an unlimited number of days as long as the hospital stay is medically necessary and authorized by UnitedHealthcare or contracting providers. When you are admitted to an Inpatient Hospital and then subsequently transferred to another Inpatient Hospital, you pay the co-payment charged for the first hospital admission. You do not pay a co-payment for the second hospital admission; the co-payment is waived.

**A benefit period begins the day you go to a hospital. The period ends when you have not received care in a hospital or skilled nursing facility for 60 consecutive days. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the skilled nursing facility care co-payment, if applicable, for each benefit period. There is no limit to the number of benefit periods you can have.

What is COBRA?
The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers with group health benefit plans to offer employees the opportunity to continue temporarily their group health care coverage under their employer's plan if their coverage otherwise would cease due to termination, layoff or other change in employment status (referred to as "qualifying events").

How long must COBRA continuation coverage be available?
- ❑ Up to 18 months for termination or reduction of hours
- ❑ Up to 29 months to employees who are determined to have been disabled at any time during the first 60 days of COBRA coverage and to the disabled employee's nondisabled beneficiaries.
- ❑ Up to 36 months for spouses and dependents due to an employee's death, divorce or legal separation.

What plans are subject to COBRA?
Group health, vision, dental and health care spending account (EMSP) plans are subject to COBRA.

What specific events can be qualifying events?
- ❑ Death of employee
- ❑ Voluntary or involuntary termination of employment (other than by reason of gross misconduct)
- ❑ Retirement
- ❑ Reduction in hours
- ❑ Divorce or legal separation
- ❑ Dependent child ceasing to be a dependent

How much does COBRA cost for City-sponsored plans?

COBRA	70/30/3000 EPO Monthly Rates	75/25/HRA EPO Monthly Rates
Member only	$392	$493
Member + spouse	$1,023	$1,164
Member + childr(ren)	$638	$803
Member + family	$1,260	$1,054

COBRA Monthly Dental Plan Rates			
Coverage Level	Dental PPO	Dental HMO	Dental EPO
Member Only	$24.61	$7.92	$18.38
Member + Spouse	$49.24	$14.58	$33.81
Member + Child(ren)	$50.21	$14.65	$33.99
Member + Family	$74.86	$20.60	$47.80

COBRA Monthly Vision Plan Rates		
Coverage Level	Standard Plan	Buy-up Plan
Member Only	$4.89	$5.88
Member + Spouse	$8.93	$10.73
Member + Child(ren)	$9.37	$11.26
Member + Family	$14.42	$17.35

Women's Health Cancer Rights Act (WHCRA) Enrollment Notice
If you have had or plan to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

The benefits provided are subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like additional information on WHCRA benefits, call your plan administrator at 800-736-1364.

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

Important Notice About Your Prescription Drug Coverage & Medicare
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Dallas and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City of Dallas has determined that the prescription drug coverage offered by United MedicareRx offered by UnitedHealthcare is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.
However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you are enrolled in the City's Active employee or Pre-65 retiree EPO health plan; that coverage pays for medical expenses in addition to prescription drug expenses which are included the plan's design. As a retiree, if you decide to join a non-City of Dallas sponsored Medicare drug plan, your current City of Dallas coverage will be affected as you cannot be enrolled in two plans. If you decide to join a Medicare drug plan as a retiree that is not sponsored by the City of Dallas and drop your current City of Dallas coverage, be aware that you and your dependents will not be able to get this coverage back. *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with the City of Dallas and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...
Please contact the Benefits Service Center at 1-888-752-9122 or send written correspondence to the following address: Benefits Service Center, 1500 Marilla Street, 1DS, Dallas, TX 75201

NOTE: This notice will be provided in each annual enrollment guide and if this coverage through the City of Dallas changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage: visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty). To receive a copy of this notice, please use the contact information listed below.

City of Dallas – Benefits Department
Benefits Service Center
1500 Marilla Street, 1DS, Dallas, TX 75201
Phone Number: 1-888-752-9122

CITY OF DALLAS
Notice of Medical Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting Your Personal Health Information
The City of Dallas understands that your health information is personal and private. We are committed to protecting the privacy of your health information and the health information of your family members that we, and the Health Plans we sponsor for the benefit of our employees, receive and maintain. This health information is referred to in this Notice as "your protected health information."
We are required by law—the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA")—to:

- ❑ Make sure that your protected health information is kept private
- ❑ Give you this Notice of our legal duties and privacy practices with respect to your protected health information
- ❑ Follow the terms of this Notice, as currently in effect.

This Notice is effective April 14, 2003, and applies to all of the medical records the City and our business associates maintain that have been provided to us through the Health Plans. If you are covered under one of the City's insured Health Plans, you may receive a similar notice from your Health Plan's insurance carrier.

How Your Personal Health Information May be Used and Disclosed
The City's Health Plans may disclose your protected health information to the claims payers, to business associates, and to certain employees of the City. These individuals may only use your protected health information for Health Plan payment and operations and certain other limited purposes, as described below. We may not and will not use your protected health information for any employment-related actions or decisions or in connection with any of the City's non-Health Plan benefits. Violations of these rules are subject to disciplinary action.

The City has certified that it will not use or disclose your protected health information other than as provided in this Notice or as required by law. Any business associates who are given your protected health information must agree to be bound by these restrictions and conditions concerning your protected health information.

Health Plan Payment: We will use and disclose your protected health information for Health Plan payment activities. For example, the Health FSA third party administrator ("TPA") will use protected health information to determine coverage eligibility, process reimbursement claims, and coordinate benefits with other health care programs or insurance carriers.

Health Care Operations: We may use and disclose your protected health information for Health Plan operations, such as monitoring the Carriers and TPAs to ensure that they are properly and accurately paying claims in accordance with the terms of the Health Plan documents, and that they are providing proper and timely services to you as required under the Health Plans. Designated employees of the City may receive, use, and disclose protected health information when assisting you with Health Plan problems or questions, such as eligibility, benefit coverage, and appeals. Protected health information also may be used when conducting quality assessment and improvement activities; underwriting and soliciting bids from potential Carriers or TPAs, establishing City and employee premium contributions and funding-related activities; determining need for disease management programs; submitting claims for stop-loss coverage; arranging medical or legal reviews or fraud detection programs; and managing costs. We may also share your protected health information with business associates who assist us in monitoring Health Plan costs, utilization, plan design, Health Plan disputes, and similar Health Plan payment and operations. Our auditors, attorneys, and other business associates may use protected health information in assuring accurate and complete compliance with the Health Plans' terms.

As Required By Law or Judicial Order: We will disclose information about you when required to do so by federal, state or local law, including when required by court orders and subpoenas, or by the police or other authorized governmental organizations. For example, we may disclose protected health information when required by a domestic relations order, a child support order, or a court order involving a civil lawsuit or criminal prosecution. In most instances, this information will be provided by the Carrier or the TPA.

To Avert a Serious Threat to Health or Safety: We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of others. Any disclosure, however, would only be to someone able to help mitigate or prevent the threat to health or safety and only to the extent necessary to mitigate or prevent the problem.

Special Situations: Although unlikely, we may be required or permitted by HIPAA to use or disclosure protected health information in certain special situations, including, but not limited to, disclosures: (1) required to comply with workers' compensation requirements; (2) to assist law enforcement, such as to identify a missing person or witness; (3) to health oversight agencies, for example in the course of Medicare audits and compliance with other applicable laws; and (4) to report on public health risks, such as to report adverse reactions to medicines.

Disposal of Protected Health Information: Once we no longer need your protected health information we will either destroy it, return it, or if neither is feasible, we will store it securely and prohibit further uses and disclosures except to the extent use or disclosure is unavoidable.

Your Written Authorization to Release Information

In addition to the uses and disclosures of protected health information described in this Notice or as provided in HIPAA regulations, your protected health information will be used or disclosed only with your written permission. If you give us your written authorization to use or disclose your protected health information, you may revoke that permission, in writing, at any time, but not for any actions we have already taken. If you revoke your permission, you must be specific about which entity's permission is being revoked.

Your Rights Regarding Your Protected Health Information

Right to Inspect and Copy: You have the right to inspect and copy your protected health information that is held in the Health Plan's official file, with certain exceptions, such as you cannot be given access to psychotherapy notes or information prepared for litigation. If you request a copy of the information, you may be charged a fee for the related costs, such as copying and mailing. If your request to inspect or copy your protected health information has been denied, you will be notified in writing of your rights of appeal at that time.

Right to Amend: If you feel that protected health information held in the Health Plan's official file is incorrect or incomplete, you must submit a written request that the information be amended; you must support the basis for your request. We are not required to grant your request if we do not maintain or did not create the information, or if it is correct. We must respond to your request within 60 days, unless a written notice of a 30-day extension is provided.

Right to an Accounting of Disclosures: You have the right to request an accounting, or list, of certain uncommon disclosures of your protected health information. Your request for a list of disclosures must state the time period for which you are requesting the accounting, but your request may not cover a time period that is longer than six years and may not include the period before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronically). The first list you request within a 12-month period will be free. For additional lists, you may be charged for the costs of providing the list. Your request for an accounting of the disclosures of your protected health information must be responded to no later than 60 days after receipt of the request, unless a written notice of a 30-day extension is provided.

Right to Request Restrictions: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for Health Plan payment or operations. You also have the right to request a limit on the protected health information disclosed about you to someone who is involved in your care or the payment for your care, such as a family member or friend when you are incapacitated or unavailable. In your request for restrictions, you must indicate: (1) what information you want to limit; (2) whether you want to limit the use, disclosure, or both; and (3) to whom you want the limits to apply, for example, prohibit disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that communications with you regarding your protected health information be made in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Your request must specify how or where you wish to be contacted. Although we are not required to agree to your request, we will accommodate all requests we deem reasonable.

Use of Personal Representatives: Your personal representative may act on your behalf. For example, a parent is a personal representative of a dependent minor, and a person with your power of attorney or a court order may be your personal representative.

Changes To This Notice

We reserve the right to change this Notice and will distribute as required. We reserve the right to make the revised Notice effective for protected health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice on the Plan websites at **http://dallascityhall.com/human_resources/benefits_retirees.html** and **www.cityofdallasbenefits.com**.

Complaints and Questions

If you have questions about your HIPAA privacy rights or if you believe your rights have been violated, you may contact the City or one of the Health Plan representatives listed below or you may file a complaint with the Department of Health and Human Services. You will not be penalized for filing a complaint.

Human Resources Department	Health Plan Representatives Contact Information	
ATTN: Benefits Division 1500 Marilla Street, Room 1D South Dallas, Texas 75201-6390 Phone: 1-888-752-9122 Fax: 1-888-202-5571	United Healthcare (UHC) EPO Plans (75/25/HRA & 70/30) Caremark (CVS) - Prescription Services United Healthcare (UHC) - Flexible Spending Accounts United Healthcare (UHC) - Dental PPO & EPO Plans United Healthcare (UHC) - Dental HMO Plan United Healthcare (UHC) - Vision Standard & Buy-up Plans OptumHealth EAP (Employee Assistance Program) Colonial Life - Voluntary Benefit Plans AFLAC - Voluntary Benefit Plans	800-736-1364 855-465-0023 877-311-7849 877-816-3596 800-232-0990 800-638-3120 800-586-6875 800-325-4368 800-992-3522

Special Enrollment Notice
If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for your other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or place for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days following the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact the Benefits Service Center at 1-888-752-9122.

Wellness Program Disclosure
If it is unreasonably difficult for you to achieve the standards for a reward under the wellness program due to a medical condition, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call the Benefits Service Center at 1-888-752-9122, and we will work with you to develop another way to qualify for the reward.

Children's Health Insurance Program Notice

Medicaid and the Children's Health Insurance Program (CHIP) Free Offer or Low-Cost Health Coverage to Children & Families

If you are eligible for health coverage from your employer but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for one of these programs, you can contact your state Medicaid or CHIP office, or dial **1-877-KIDS-NOW**. You may also go to **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it has been determined that your or your dependents qualify for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan—granted that you and your dependents are eligible but not already enrolled in your employer's plan. This is called a "special enrollment" opportunity. **You must request coverage within 60 days of being determined eligible for premium assistance.**

You may be eligible for payment assistance with your employer's health plan premiums. You should contact your state for information on eligibility:

Texas Residents: Go to **http://www.gethipptexas.com/** or call **1-800-440-0493**.

To see which states have implemented a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you may use the following resources:

U. S. Department of Labor
Employee Benefits Security Administration
Website: www.dol.gov/ebsa
Phone: 1-866-444-EBSA (3272)
OMB Control Number 1210-0137 (expires 9-30-2013)

U. S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Website: www.cms.hhs.gov
Phone: 1-877-267-2323, Ext. 61565

Voluntary Benefits: Colonial Life

Not Sponsored by the City of Dallas
(available on an individual basis)

- Accident Insurance
- Cancer Insurance

The City of Dallas does not sponsor the Voluntary Benefits disclosed on the following page.

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Take Advantage of What Colonial Life Has to Offer!

You have the opportunity to apply for personal insurance products from Colonial Life! These benefits can enhance your current benefits portfolio and can be customized to fit your individual needs.

Also:

- Coverages are available for you and your family, with most products.
- You will enjoy the convenience of premium payment through pension deductions.
- You will have the ability to take most coverages with you if you change jobs or retire.

The following insurance plans will be offered during your enrollment:

Accident Insurance helps offset the direct and indirect expenses such as co-payments, deductibles and other costs not covered by traditional health care plans.

Cancer Insurance helps offset the out-of-pocket medical and indirect, non-medical expenses related to cancer treatment.

A Colonial Life benefits counselor will explain how these benefits can help protect you and your family. Your insurance needs can be reviewed in just a few minutes. With Colonial Life, you can select benefits that help meet your individual needs.

Products have exclusions and limitations that may affect benefits payable. See the Outline of Coverage for complete details.

Pre-65 retirees may enroll in these Colonial Life products by following these steps:

- Gather any information you may need to enroll, such as dependents' names, birth dates, ages, Social Security numbers and addresses.
- Call the Benefits Service Center at 1-888-752-9122 to be transferred to a benefits counselor who will be able to answer your questions and enroll you in the coverage of your choice.

To make changes or apply for Colonial voluntary benefits, please see a Colonial Life benefits counselor who will be available onsite during Open Enrollment or call the Benefits Service Center at 1-888-752-9122; when calling during Open Enrollment, select call options 1, 2 and 1.

For questions regarding your existing Colonial Life coverage, contact the Colonial Life Policyholder Services Department at 1-800-325-4368 or visit the Colonial Life website at www.coloniallife.com.

Colonial Life & Accident Insurance Company
1200 Colonial Life Boulevard, Columbia, SC 29210
Policyholder Services: 1-800-325-4368
Website: www.coloniallife.com

Colonial Life
Making benefits count.

VENDOR CONTACT LIST

City of Dallas HR-Benefits Service Center	
City of Dallas Benefits Website Phone	www.cityofdallasbenefits.com 1-888-752-9122
City of Dallas Website	www.dallascityhall.com
Medical Plan	
United Healthcare (UHC) EPO and HRA Plans Membership Services EPO/HRA Care 24 Website	 1-800-736-1364 1-800-586-6875 www.myuhc.com
Pharmacy Plan	
CVS/Caremark Website	1-855-465-0023 www.caremark.com
Vision Plan (UHC)	
Vision Services Website	1-800-638-3120 www.myuhcvision.com
Dental Plan (UHC)	
Dental HMO Dental PPO and EPO Website	1-800-232-0990 1-877-816-3596 www.myuhcdental.com
Voluntary Benefits - Colonial Life	
Membership Services Website	1-800-325-4638 www.coloniallife.com
COBRA (UHC)	
Membership Services Website	1-866-747-0048 www.uhcservices.com
Employee Retirement Fund	
Phone Website	214-580-7700/1-877-246-1791 www.dallaserf.org
Dallas Police and Fire Pension	
Phone Website	1-800-638-3861/214-638-3863 www.dpfp.org
Wellness (WellAware)	
WellAware Website	http://cod/HumanResources/WellAware/index.htm
UnitedHealthcare Group Medicare Advantage	
Membership Services (To ask questions, enroll or change plans) Website	1-800-950-9355 www.uhcretiree.com
Medicare Part D Prescription Plan (UHC)	
Membership Services (To ask questions only) City of Dallas Benefits Service Center (To enroll or change plans) Website	1-888-556-6648 1-888-752-9122 www.unitedmedicarerx.com
AARP	
Membership Services Website	1-800-392-7537 www.aarphealthcare.com

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City of Dallas Publication No. 11-12:68

Additional copies may be obtained from:
The Benefits Service Center @ 1-888-752-9122

About this Guide

This 2013 Benefits and Enrollment Guide describes, in non-technical language, the essential features of the City of Dallas Health Benefits Plan (The Plan). This Guide has been prepared as a reference only. It is not an official Master Plan Document for the City of Dallas Health Benefits Plan, which includes dental, vision, life and voluntary benefits. The terms and conditions of coverage under The Plan are determined solely by the Master Plan Document as adopted by the City of Dallas City Council. If there is a difference between what you read in this Guide and what you read in the official Summary Plan Document (SPD), the official Master Plan Document will govern.

City of Dallas

Department of Human Resources
Benefits Service Center | 1500 Marilla Street, Room 1DS | Dallas, TX 75201
1-888-752-9122 (ph) | 1-888-202-5571 (fax)

The Benefits Service Center is open Monday through Friday from 8:15 a.m. to 5:15 p.m.

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Summary Plan Description

City of Dallas
Pre-65 Retiree
HRA Choice

Effective: January 1, 2013
Group Number: 708872

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: (800) 846-4678;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, Utah 84130-0555; and
- Online assistance: **www.myuhc.com**.

City of Dallas is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- 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.

City of Dallas 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. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. City of Dallas is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the City of Dallas Health Plan works. If you have questions contact City of Dallas Benefits Service Center or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can request printed copies of the SPD by contacting City of Dallas Benefit Service Center.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- City of Dallas is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

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 enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time or permanent part-time Participant who is scheduled to work at least 20 hours per week or a person who retires while covered under the Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 14, *Glossary*;
- you or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian or a tax dependent grandchild;
- a child age 26 or over who is or becomes disabled and dependent upon you.
- Certain survivors (see Survivorship Coverage in Section 12)

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the City of Dallas Benefit Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the City of Dallas Benefit Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information.*

Cost of Coverage

You and City of Dallas share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld -

and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their eligible Dependents. Therefore, the value of City of Dallas' cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and the City Council reserves the right to change contributions required by the Plan.

You can obtain current contribution rates by calling City of Dallas Benefit Service Center.

How to Enroll

To enroll, call City of Dallas Benefit Service Center within 30 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 30 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1. Retirees who previously waived coverage cannot re-enroll.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact City of Dallas Benefit Service Center within 30 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once City of Dallas Benefit Service Center receives your properly completed enrollment, coverage will begin on your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first of the month following the date City of Dallas Benefit Service Center receives notice of your marriage, provided you notify City of Dallas Benefit Service Center within 30 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify City of Dallas Benefit Service Center within 30 days of the birth, adoption, or placement.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- registering a Domestic Partner;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact City of Dallas Benefit Service Center within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact City of Dallas Benefit Service Center within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact City of Dallas Benefit Service Center within 30 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status 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 above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical 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.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Out-of-Pocket Maximum;
- Coinsurance.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Network Physician or health care professional you prefer each time you need to receive Covered Health Services.

You are eligible for Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. Except as specifically described within the SPD benefits are not available for services provided by a non-Network provider.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services and Covered Health Services received at an Urgent Care Center outside your geographic area are always paid as Network Benefits.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a 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. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of City of Dallas or UnitedHealthcare.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will not be paid.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

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

Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition in Section 14, *Glossary*. For certain Covered Health Services, the Plan will not pay these expenses until you have met your Annual Deductible. City of Dallas has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a Network provider. If you do not show your ID card, a Network provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services Expenses before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year. The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drugs*.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

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. Copays do not count toward the Out-of-Pocket-Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance - Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 70%, you are responsible for paying the other 30%. This 30% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year. The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drugs*.

The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

Plan Features	Applies to the Out-of-Pocket Maximum?
Copays	No
Payments toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for non-Covered Health Services	No

Lifetime Maximum Benefit

The Lifetime Maximum Benefit is the most the Plan will pay for Benefits during the entire period you are enrolled under this Plan offered by City of Dallas.

SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact 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 you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components and notification requirements are subject to change without notice. As of the publication of this SPD, the Personal Health Support 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 a certain chronic or complex condition, 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 toll-free number on your ID card.]

Requirements for Notifying Personal Health Support

In most cases, Network providers are responsible for notifying Personal Health Support before they provide these services to you. However, you are responsible for notifying the Personal Health Support staff prior to receiving a service for:

- dental services - accident only;
- obesity surgery; and
- transplantation services.

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB).*

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of the coinsurance percentage that applies when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network
Annual Deductible[2]	
■ Individual	$2,500
■ Family (not to exceed $2,500per Covered Person)	$5,000
Annual Out-of-Pocket Maximum[2]	
■ Individual	$6,000
■ Family (not to exceed $6,000 per Covered Person)	$12,000
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details.*

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Acupuncture Services	75% after you meet the Annual Deductible
Ambulance Services ■ Emergency Ambulance	75% after you meet the Annual Deductible
Cancer Resource Services (CRS) ■ Hospital Inpatient Stay	75% after you meet the Annual Deductible
Congenital Heart Disease (CHD) Surgeries	75% after you meet the Annual Deductible
Dental Services - Accident Only	75% after you meet the Annual Deductible
Diabetes Services ■ Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 15, *Prescription Drugs.*
Durable Medical Equipment (DME)	75% after you meet the Annual Deductible
Emergency Health Services - Outpatient Emergency services received at a non-Network Hospital are covered at the Network level.	75% after you meet the Annual Deductible
Extreme Vision	75% after you meet the Annual Deductible
Hearing Aids	75% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Home Health Care Up to 30 visits per calendar year	75% after you meet the Annual Deductible
Hospice Care	75% after you meet the Annual Deductible
Hospital - Inpatient Stay	75% after you meet the Annual Deductible
Kidney Resource Services (KRS) (These Benefits are for Covered Health Services provided through KRS only)	75% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics – Outpatient	75% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient	75% after you meet the Annual Deductible
Mental Health Services ■ Hospital - Inpatient Stay ■ Physician's Office Services	75% after you meet the Annual Deductible 75% after you meet the Annual Deductible
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders ■ Hospital - Inpatient Stay ■ Physician's Office Services	75% after you meet the Annual Deductible 75% after you meet the Annual Deductible
Nutritional Counseling	75% after you meet the Annual Deductible
Obesity Surgery ■ Physician's Office Services ■ Physician Fees for Surgical and Medical Services ■ Hospital - Inpatient Stay See Section 6, *Additional Coverage Details* for limits	75% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Ostomy Supplies	75% after you meet the Annual Deductible
Pharmaceutical Products – Outpatient	75% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	75% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	75% after you meet the Annual Deductible
Pregnancy - Maternity Services ■ Physician's Office Services ■ Hospital - Inpatient Stay ■ Physician Fees for Surgical and Medical Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	100% Deductible does not apply 75% after you meet the Annual Deductible 75% after you meet the Annual Deductible
Preventive Care Services ■ Breast Pump ■ Physician Office Services ■ Lab, X-ray or Other Preventive Tests	100% 100% 100%
Private Duty Nursing - Outpatient Up to 30 visits per calendar year	75% after you meet the Annual Deductible
Prosthetic Devices	75% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Reconstructive Procedures	
■ Physician's Office Services	75% after you meet the Annual Deductible
■ Hospital - Inpatient Stay	75% after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services	75% after you meet the Annual Deductible
■ Prosthetic Devices	75% after you meet the Annual Deductible
■ Surgery - Outpatient	75% after you meet the Annual Deductible
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits	75% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	75% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 120 days per calendar year	75% after you meet the Annual Deductible
Substance Use Disorder Services	
■ Hospital - Inpatient Stay	75% after you meet the Annual Deductible
■ Physician's Office Services	75% after you meet the Annual Deductible
Surgery – Outpatient	75% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	75% after you meet the Annual Deductible
Therapeutic Treatments – Outpatient	75% after you meet the Annual Deductible
Transplantation Services (If services rendered by a Designated Facility)	75% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Travel and Lodging (If services rendered by a Designated Facility)	For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment or transplant procedures
Urgent Care Center Services	75% after you meet the Annual Deductible
Wigs Up to $300 per calendar year.	75% after you meet the Annual Deductible

[1]In general, your Network provider must notify Personal Health Support, as described in Section 4, before you receive certain Covered Health Services. There are some Network Benefits, however, for which you are responsible for notifying Personal Health Support. See Section 6, *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services -Sickness and Injury*, *Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Lab, X-Ray and Diagnostics - Outpatient*, and *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call Personal Health Support.

This section supplements the second table in Section 5, *Plan Highlights.*

While the table provides you with benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions.*

Acupuncture Services

The Plan pays for acupuncture services for pain therapy when both of the following are true:

- another method of pain management has failed; and
- the service is performed by an MD in the provider's office.

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 14, *Glossary* for the definition of Emergency.

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

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in Section 14, *Glossary.*

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or

- visit www.urncrs.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits for Network services 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.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Facility.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include 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
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, 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.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Dental Services - Accident Only

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

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from 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 occurs 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 Injury and if extenuating circumstances exist due to the severity of the Injury.)

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:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

- 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; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Please remember that you should notify Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment. If you don't notify Personal Health Support, Benefits will be reduced by $250.

Diabetes Services

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

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.
Diabetic Self-Management Items	Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 15, *Prescription Drugs*.

Durable Medical Equipment (DME)

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

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in 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. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- burn garments;
- filters for sleep apnea machines;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, including 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 orthotic devices and 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 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. Benefits are limited as stated below.

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

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

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

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including 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 anytime and are not subject to the three year timeline for replacement.

Emergency Health Services - Outpatient

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

If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, no Benefits will be paid.

Extreme Vision

The Plan's pays for Benefits for the following:

- necessary contact lenses or eyeglasses to correct vision problems following cataract surgery; and

- evaluation, fitting cost and purchase cost of contact lenses if there is a diagnosis of Karatoconus.

Benefits are limited to once every 12 months.

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 do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons 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.

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 in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, intermittent schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

Personal Health Support 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" simply because there is not an available caregiver.

Benefits are limited to 30 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician service for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital 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.*

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

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined in Section 14, *Glossary.*

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

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by Personal Health Support; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, 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.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include, but are not limited to:

- lab and radiology/x-ray; and
- mammography.

Benefits under this section include:

- 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.* Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services 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:

- the facility charge and the charge for supplies and equipment;
- 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.*

Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services; and
- crisis intervention.

Benefits include the following ser vices provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

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. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. 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 Covered Person and is not mandatory.

Please remember you should notify the MH/SUD Administrator to receive these Benefits in advance of any treatment. Please call the phone number that appears on your ID card.

Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders

The Plan pays Benefits for psychiatric services for Autism Spectrum 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 or property and impairment in daily functioning.

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

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provided-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care with regard to services for Autism Spectrum Disorder. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Please remember you should notify the MH/SUD Administrator to receive the Benefits for Autism Spectrum Disorder in advance of any treatment. Please call phone number that appears on your ID card.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional for Covered Persons with diabetes that require a special diet.

Obesity Surgery

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician.

Morbid obesity means morbid or clinically severe obesity correlated with a Body Mass Index (BMI) of 40 kg/m2 or with being 100 pounds over ideal body weight and 30% over ideal body weight with underlying medical conditions

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Surgery is limited to a lifetime benefit of $5,000. There is no calendar year limit for non-surgical treatment.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits

under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Physician Fees for Surgical and Medical Services

The Plan pays 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 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 allergy injections and hearing exams in case of Injury or Sickness.

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

Pregnancy - Maternity Services

Employee and Dependent Spouse Only

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for postnatal care, delivery, and any related complications.

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 Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

For Dependent Children Only

Pregnancy Benefits for Dependent children are limited to Covered Health Services for Complications of Pregnancy. For a complete definition of Complications of Pregnancy, see Section 14, *Glossary*.

Benefits are payable for Covered Health Services for the treatment of Complications of Pregnancy given to a Dependent child while covered under this Plan.

Benefits for Complications of Pregnancy are paid in the same way as benefits are paid for Sickness.

Benefits for Complications of Pregnancy which result in the delivery of a child are payable for at least:

- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery; and
- 96 hours of inpatient care for the mother and newborn child following a cesarean section.

The following are not considered Complications of Pregnancy:

- false labor;
- occasional spotting;
- rest prescribed by a Physician;
- morning sickness; and
- other conditions that may be connected with a difficult pregnancy but are not a classifiably distinct complication.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

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

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

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Benefits are limited to 30 visits per Covered Person per calendar year.

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 provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

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 would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. 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.

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. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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 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 the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. 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 14, *Glossary*.

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

> Please remember that you should notify Personal Health Support five business days before undergoing a Reconstructive Procedure. When you provide notification, Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;

- Manipulative Treatment;
- speech therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Benefits are limited to:

- 20 visits per calendar year for physical therapy;
- 20 visits per calendar year for occupational therapy;
- 20 visits per calendar year for speech therapy;
- 20 visits per calendar year for Manipulative Treatment.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays 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 those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

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

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 arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physicians services for radiologists, anesthesiologists and pathologists.

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, including anesthesiologists, consulting Physicians, pathologists and radiologists, are described in this section under *Physician Fees for Surgical and Medical Services.*

UnitedHealthcare 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
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

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

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons 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 14, *Glossary.*

Benefits are limited to 120 days per calendar year.

Substance Use Disorder Services

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

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management;
- crisis intervention; and
- detoxification (sub-acute/non-medical).

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

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. The Substance Use Disorder Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use 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 Covered Person and is not mandatory.

Please remember you should notify the MH/SUD Administrator to receive these Benefits in advance of any treatment. Please call phone number that appears on your ID card.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

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

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

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

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 arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *U.S. Food and Drug Administration (FDA)*-approved TMJ implants only when all other treatment has failed.

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.

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 healthcare professionals when:

- education is 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.

Benefits under this section include:

- 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.*

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network provider and received at a Designated Facility. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. 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 that are provided by a Network provider at a Network Hospital. You are not required to notify United Resource Networks or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

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.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the telephone number on your ID card for information about these guidelines.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Facility.

Travel and Lodging

United Resource Networks or Personal Health Support will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD);
- transplantation services; and
- cancer-related treatments.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment, the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $75 per day for the patient or up to $100 per day for the patient plus one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility (for CRS and transplantation) or the CHD facility. UnitedHealthcare

must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

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.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *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.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis regardless of the reason of hair loss.

Benefits are limited to $300 per calendar year.

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:
Health and well-being resources available to you, including:
- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

City of Dallas believes in giving you the tools you need to be an educated health care consumer. To that end, City of Dallas has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
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 own health. UnitedHealthcare and City of Dallas 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 text.

Consumer Solutions and Self-Service Tools

Employee Assistance Program (EAP)

UnitedHealthcare offers free counseling and referral services nationwide through the Employee Assistance Program (EAP). Using a solution focused approach to care, they tailor their interventions to meet your individual needs. The program can help you and your immediate family members cope with issues such as:

- family or relationship problems;
- parenting difficulties;
- work-related problems;
- financial and legal issues;
- substance use or abuse;
- grief and loss; and
- anxiety.

Call the toll-free phone number on the back of your ID card to speak to a specially trained, master's-level specialist who will recommend the right resources for your specific life

concern. Services are available any time, 24 hours a day, seven days per week and are strictly confidential in accordance with state and federal laws.

Health Assessment

You are invited to learn more about your health and wellness at **www.myuhc.com** 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, except as stated in Section 17.

To find the health assessment, log in to **www.myuhc.com**. 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 the number on the back of your ID card.

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;
- smoking 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 – City of Dallas' way of helping you meet your health and wellness goals.

NurseLine℠

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. 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 City of Dallas 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 in Spanish.

NurseLine is available to you at no cost.

Note: If you have a medical emergency, call 911 instead of calling NurseLine.

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. 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** 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 logging onto **www.myuhc.com**.

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 the number on the back of your ID card.

UnitedHealth Premium℠ Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium 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 and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- 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;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;

- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** 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 Physician.

Disease and Condition Management Services

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 even 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 and 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 the number on the back of your ID card.

HealtheNotes℠

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

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

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

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

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. 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 the toll-free number on the back of your ID card.

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.

SECTION 8 - 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, *Additional Coverage Details.*

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights.* Limits may also 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, *Plan Highlights.* Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

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

Alternative Treatments

1. acupressure
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. Rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details.*

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

   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. Examples include treatment

of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

   - extractions (including 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 accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details.*

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

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details.*

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

   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 for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details.*

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

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, *Additional Coverage Details*:

   Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter.

3. cranial banding;

4. the following items are excluded, even if prescribed by a Physician:

   - blood pressure cuff/monitor;
   - enuresis alarm;

- non-wearable external defibrillator;
- trusses;
- ultrasonic nebulizers;

5. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

6. the replacement of lost or stolen prosthetic devices;

7. 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, *Additional Coverage Details* ; and

8. oral appliances for snoring.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the prescription portion of the Plan, which is administered by Caremark. Please visit **www.caremark.com** or call the number on your ID Card for more information.

1. Prescription Drugs for outpatient use that are filled by a prescription order or refill;

2. self-injectable medications (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);

3. growth hormone therapy;

4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and

5. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *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.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details.* Routine foot care services that are not covered include:

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

2. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet;
   - 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;

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. treatment of flat feet;

4. shoe inserts;

5. arch supports;

6. shoes (standard or custom), lifts and wedges; and

7. shoe orthotics.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

   - elastic stockings, ace bandages, diabetic strips, and syringes; and
   - urinary catheters.

This exclusion does not apply to:

- ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details.*
- disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*; or
- diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details.*

2. 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; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details.*

Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders* [2]and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details.*

1. services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that , in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:

3. not consistent with generally accepted standards of medical practice for the treatment of such conditions;

4. not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;

5. not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or

6. not clinically appropriate for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

7. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

8. Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;

9. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal);

10. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;

11. tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act;

12. learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

13. mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

14. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction; and

15. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

1. nutritional or cosmetic therapy using high dose 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*, and except as defined under *Nutritional Counseling* in Section 6, *Additional Coverage Details*;

3. food of any kind. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are the only source of nutrition and even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - foods to control weight, treat obesity (including 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 and electrolyte supplements; and

4. 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. supplies, equipment and similar incidentals for personal comfort. Examples include:

   - air conditioners;
   - air purifiers and filters;

- batteries and battery chargers;
- dehumidifiers and humidifiers;
- ergonomically correct chairs;
- non-Hospital beds, comfort beds, motorized beds and mattresses;
- breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
- car seats;
- chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
- electric scooters;
- 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; and
- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact 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, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity; and

4. treatment of benign gynecomastia (abnormal breast enlargement in males).

Preexisting Conditions

1. Benefits for the treatment of a Preexisting Condition are excluded unless you have had Continuous Creditable Coverage for 12 months. Preexisting Condition is defined in Section 14, *Glossary*.

   This exclusion does not apply to Covered Persons under age 25.

Procedures and Treatments

1. biofeedback;

2. 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);

3. rehabilitation services and Manipulative 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;;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

8. psychosurgery (lobotomy);

9. treatment of tobacco dependency;

10. chelation therapy, except to treat heavy metal poisoning;

11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, such as asthma or allergies;

12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

13. sex transformation operations;

14. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*;

15. medical and surgical treatment of hyperhidrosis (excessive sweating);

16. the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations;

17. upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor or cancer. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment, except as treatment of obstructive sleep apnea; and

18. breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details.*

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

- prior to ordering the service; or
- after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

1. health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment

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

2. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);

3. surrogate parenting, donor eggs, donor sperm and host uterus;

4. the reversal of voluntary sterilization;

5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

6. prenatal, labor and delivery coverage for enrolled Dependent children except those that have Complications of Pregnancy as defined in Section 14, Glossary;

7. fetal reduction surgery;

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

   This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

9. contraceptive supplies and services(certain contraceptives are covered at 100%, not subject to the Annual Deductible, per Health Care Reform. Contact UnitedHealthcare for additional information);

10. services provided by a doula (labor aide); and

11. parenting or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);

3. transplants that are not performed at a Designated Facility (this exclusion does not apply to cornea transplants); and

4. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary;*

3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

4. Private Duty Nursing received on an inpatient basis;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in Section 6, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants; and

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;

2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

3. purchase cost and associated fitting charges for eyeglasses or contact lenses;

4. bone anchored hearing aids except when either of the following applies:

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

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

5. eye exercise or vision therapy; and

6. 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; or
   - 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; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

- that do not meet the definition of a Covered Health Service in Section 14, *Glossary*;
- that 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 Covered Persons 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 which 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 Benefit Plan; or
- that exceed Eligible Expenses or any specified limitation in this SPD;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; and

8. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

- required solely for purposes of education, sports or camp, insurance, marriage or adoption; or as a result of incarceration;
- conducted for purposes of medical research;
- related to judicial or administrative proceedings or orders; or
- required to obtain or maintain a license of any type.

9. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

SECTION 9 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

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 the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and 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 Benefits

If you receive a bill for Covered Health Services from a non-Network provider as a result of an Emergency, 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 address on the back of your ID card.

Prescription Drug Benefit Claims

Prescription coverage is available through Caremark. For information on submitting your outpatient prescription drug claims, call the toll-free number on your ID Card or visit **www.caremark.com**.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting City of Dallas Benefit Service Center. 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 patient's name, age and relationship to the Participant;
- the number as shown on your 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 carrier(s).

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

The above information should be filed with us at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the 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 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, your provider, and not to a third party, even if your provider has assigned Benefits to that third party.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. 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 paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Claims
All claim forms must be submitted within 12 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 City of Dallas. This 12-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 the number on your ID card 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, post-service claim or a rescission of coverage determination as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the 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 request.

You or your enrolled Dependent may send a written request for an appeal to:

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

Customer Service: 800-736-1364

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card 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;
- post-service claim; or
- concurrent claim.

Review of an 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 will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from City of Dallas within 60 days from receipt of the first level appeal determination. City of Dallas must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. City of Dallas will review all claims in accordance with the rules established by the U.S. Department of Labor. City of Dallas's decision will be final.

Federal External Review Program

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

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

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or

- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card 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 received City of Dallas' decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; 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; and
- a decision by the IRO.

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

- is or was covered under the 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 a notification in writing to you. 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.

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 of receipt of the notice additional information that the IRO will 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.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making City of Dallas' determination. The documents include:

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

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by City of Dallas. 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 they request 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 City of Dallas' determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. 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.

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 individual or would jeopardize the individual'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 timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual'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 individual received emergency services, but has not been discharged from a facility.

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

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

After UnitedHealthcare completes 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 City of Dallas. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and

- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
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**
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
City of Dallas must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal**

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

**City of Dallas may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
City of Dallas must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal*

*UnitedHealthcare may be entitled to a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

**City of Dallas may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

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 timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against City of Dallas or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against City of Dallas or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against City of Dallas or the Claims Administrator.

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

SECTION 10 - 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 any one of the following:

- another employer sponsored health benefits 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 auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

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 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** or call the toll-free number on your ID card 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:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

- 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 pays benefits first is the one that has been in effect the longest. 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 without specifying that one party 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;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; Only expenses normally paid by the Plan will be paid under COB; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

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 Participant 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.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the primary plan's allowable expense.
- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.

- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense When This Plan is Secondary

When this Plan is secondary, the allowable expense is the primary plan's Network rate. 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.

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

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

- employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary

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 are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Right to Receive and Release Needed Information

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

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

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 UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If City of Dallas pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to City of Dallas if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment City of Dallas made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

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

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

SECTION 11 - 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 you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent 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 provides an advancement of benefits to you or your Dependent during the time period of the Deductible and/or meeting the 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 it has advanced 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 you 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 considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a

Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

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

Right to Reimbursement

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

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity who caused the Sickness, Injury or damages;
- City of Dallas in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers' compensation coverage; or
  - any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
- the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- 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) or judgment, 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.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - complying with the terms of this section;
  - providing any relevant information requested;
  - signing and/or delivering documents at its request;
  - notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - responding 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 before releasing any party from liability or payment of medical expenses.
- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- you may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- 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 provided for a Sickness or Injury caused by a third party.
- the Plan's rights will not be reduced due to your own negligence.
- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including 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 apply to the parents, guardian, or other representative of a Dependent child 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.
- 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.

- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- if a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Subrogation – 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. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

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

When your coverage ends, City of Dallas 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 coverage ended, even if the underlying medical condition occurred before your coverage ended.

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

- the last day of the month your employment with the Company ends;
- the date the Plan ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you are no longer eligible;
- the last day of the month UnitedHealthcare receives written notice from City of Dallas to end your coverage, or the date requested in the notice, if later; or
- the last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

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

- the date your coverage ends;
- the last day of the month you stop making the required contributions;
- the last day of the month UnitedHealthcare receives written notice from City of Dallas to end your coverage, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

The Plan will provide written notice to you that your coverage has ended if any of the following occur:

- you permit an unauthorized person to use your ID card or you use another person's ID card;
- you knowingly give UnitedHealthcare false material information including, but not limited to, false information relating to another person's eligibility or status as a Dependent;

- you commit an act of physical or verbal abuse that imposes a threat to City of Dallas' staff, UnitedHealthcare's staff, a provider or another Covered Person; or
- you violate any terms of the Plan.

Note: City of Dallas has the right to demand that you pay back Benefits City of Dallas paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to City of Dallas proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon City of Dallas' request, that the child continues to meet these conditions.

The proof might include medical examinations at City of Dallas' expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under COBRA.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if City of Dallas is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

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

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

- a Participant;

- a Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines 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 considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months 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 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.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. 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 Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

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

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation 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 the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

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

Once you have notified the Plan Administrator, 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 City of Dallas Benefit Service Center 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 the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator 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 Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

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

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- 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 Participant 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 Participant and the Participant'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, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required

to pay more than the regular contribution amount, if any, for continuation of health coverage.

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

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

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant'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 the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

Survivorship Coverage

If the employee dies while covered under the Plan, the surviving spouse and any eligible dependents may continue coverage under the Plan until the end of the month following a period of 90 days subsequent to the employee's death. After the initial 90 days following the employee's date of death, coverage is then available to the surviving spouse and any eligible dependents through the COBRA provision, except for a surviving spouse of an active uniformed officer killed in the line of duty. A surviving spouse of an active uniformed officer may continue coverage on the existing plan at active rates. If a surviving spouse remarries, coverage under the Plan will terminate.

A surviving spouse who is covered under a retiree Plan may continue coverage as long as he/she is eligible for pension benefits. Any dependents acquired through the remarriage of a retired employee's surviving spouse will not be eligible for coverage under the Plan.

A surviving spouse and eligible dependents of a retired employee may remain in the Plan after the death of the retired employee:

- If the person was covered as a dependent spouse of the deceased retired employee at the time of the retired employee's death and is eligible to receive pension benefits;
- If carried as a dependent child, the person remains a dependent of the surviving spouse, but only if the spouse is receiving monthly survivor's benefits from one of the retirement funds.

Coverage for all surviving dependents ceases if coverage for the surviving spouse stops because of death, termination of monthly benefits, or any other reason.

A retired employee, or a surviving spouse or dependent who is eligible for Medicare participation by reason of age or disability or any other reason, must enroll and remain enrolled in Medicare Parts A and B in order to retain eligibility in the Plan.

The City will pay the Medicare Part A monthly premium on behalf of the retired employees and spouses of retired employees who are not otherwise qualified for Medicare. Retired employees are responsible for notifying the City, otherwise, they will be responsible for payment of the Medicare Part A premium. The retired employee and retired employee's spouse are responsible for payment of all Medicare Part B premiums.

If a retired employee is enrolled in this Plan on January 1, and elects to discontinue coverage in this Plan, the retired employee will not be eligible to enroll at a later date or in a subsequent plan

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and City of Dallas;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

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 medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

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 City of Dallas

In order to make choices about your health care coverage and treatment, City of Dallas believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- City of Dallas and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

City of Dallas and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. City of Dallas and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. City of Dallas and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between City of Dallas, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not City of Dallas' agents or employees, nor are they agents or employees of UnitedHealthcare. City of Dallas and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

City of Dallas and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, City of Dallas and UnitedHealthcare arranges for health care providers to participate in a Network and pay Benefits. 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. They are not City of Dallas' employees nor are they employees of UnitedHealthcare. City of Dallas and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. City of Dallas and UnitedHealthcare are not liable for any act or omission of any provider.

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

City of Dallas and the Plan Administrator are solely responsible for:

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

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;

- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

City of Dallas and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

City of Dallas and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

Information and Records

City of Dallas and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. City of Dallas and UnitedHealthcare may request additional information from you to decide your claim for Benefits. City of Dallas and UnitedHealthcare will keep this information confidential. City of Dallas and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

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

City of Dallas and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan,

for appropriate medical review or quality assessment, or as City of Dallas is required to do by law or regulation. During and after the term of the Plan, City of Dallas and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements City of Dallas 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, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, City of Dallas and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

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

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but City of Dallas recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

City of Dallas and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. City of Dallas and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD 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 SPD, but it does not describe the Benefits provided by the Plan.

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

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 Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount of Eligible Expenses you must pay for Covered Health Services in a calendar year before you are eligible to begin receiving Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights.*

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

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

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).

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

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

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as UnitedHealthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

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 patient is not allowed to choose which treatment will be received.

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.*

Company – City of Dallas.

Complications of Pregnancy – a condition suffered by a Dependent child that requires medical treatment before or after Pregnancy ends.

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

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects 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 to certain employees and their dependents whose group health insurance has been terminated.

Continuous Creditable Coverage – health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- a group health plan;
- health insurance coverage;
- Medicare;
- Medicaid;
- medical and dental care for members and certain former members of the uniformed services, and for their dependents;
- a medical care program of the Indian Health Services Program or a tribal organization;
- a state health benefits risk pool;
- The Federal Employees Health Benefits Program;
- The State Children's Health Insurance Program (S-CHIP);
- health plans established and maintained by foreign governments or political subdivisions and by the U.S. government;
- any public health benefit program provided by a state, county, or other political subdivision of a state; or
- a health benefit plan under the Peace Corps Act.

If you or your eligible Dependents were covered by any of the above plans before first becoming covered by this Plan, you should have received a Certificate of Creditable Coverage when that plan's coverage ended.

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 Claims Administrator. 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 function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which City of Dallas determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms;
- consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below;

- not provided for the convenience of the Covered Person, Physician, facility or any other person;
- included in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions.*

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community; and
- "prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

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, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient 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.

Deductible – see Annual Deductible.

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

Designated Facility – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specific conditions.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between a Participant and one other person of the same sex. Both persons must:

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent and have furnished documents to support at least two of the following conditions of such financial interdependence:
  - they have a single dedicated relationship of at least 6 months duration;
  - they have joint ownership of a residence; or
  - they have at least two of the following:
    - a joint ownership of an automobile;
    - a joint checking, bank or investment account;
    - a joint credit account;
    - a lease for a residence identifying both partners as tenants; or
    - a will and/or life insurance policies which designate the other as primary beneficiary.

The Participant and Domestic Partner must jointly sign an affidavit of domestic partnership provided by City of Dallas Benefit Service Center upon your request.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – charges for Covered Health Services that are provided while the Plan is in effect, determined as follows:

For:	Eligible Expenses are Based On:
Network Providers	contracted rates with that provider
Non-Network Providers	If you receive Covered Health Services from a non-Network provider in an Emergency, Eligible Expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or Substance Use Disorders 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.

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

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – City of Dallas.

EOB – see Explanation of Benefits (EOB).

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

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

Exceptions:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and City of Dallas may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UnitedHealthcare and City of Dallas must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

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

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, 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 or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

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

Inpatient Rehabilitation Facility – a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides physical therapy, occupational therapy and/or speech therapy on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

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

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by City of Dallas. The KRS program provides:

- specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

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

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

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

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

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the organization or individual designated by City of Dallas who provides or arranges Mental Health 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*, unless they are listed in Section 8, *Exclusions*.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by City of Dallas. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator'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 some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network provider. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Open Enrollment – the period of time, determined by City of Dallas, during which eligible Participants may enroll themselves and their Dependents under the Plan. City of Dallas determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

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

Participant – a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Personal Health Support – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

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 – 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.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that 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 City of Dallas Medical Plan.

Plan Administrator – City of Dallas or its designee.

Plan Sponsor – City of Dallas.

Preexisting Condition – any Sickness or Injury that is identified by the Plan Administrator as having been diagnosed or treated, or for which Prescription Drugs were prescribed or taken within the six months before coverage under this Plan begins (or the first day of any waiting period, if earlier). A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.

If you have Continuous Creditable Coverage, you or your Dependent will be eligible to receive Plan Benefits for a Preexisting Condition. Continuous Creditable Coverage is defined in this section.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with Pregnancy.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

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 surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

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

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the 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.

Retired Employee – an Employee who retires while covered under the Plan.

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

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights.*

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider.

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

Skilled Care – skilled nursing, teaching, and 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 patient;
- 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.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Specialist Physician.

Spouse – an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded.

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, 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 Covered Person with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members 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 doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program – a program that identifies network Physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the 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 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**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and City of Dallas may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and City of Dallas must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.
- UnitedHealthcare and City of Dallas may, in their discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that UnitedHealthcare and City of Dallas do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies must be available in published peer-reviewed medical literature that would allow UnitedHealthcare and City of Dallas to conclude that the service is promising but unproven.
  - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare and City of Dallas's discretion. Other apparently similar promising but unproven services may not qualify.

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 minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

UnitedHealthcare Services, Inc.
185 Asylum Street
Hartford, CT 06103-3408

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

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Services, Inc.. The named fiduciary of Plan is City of Dallas, the Plan Sponsor.

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

SECTION 16 HEALTH REIMBURSEMENT ACCOUNT

This section describes the healthcare expense reimbursement component of the Plan. It includes summaries of:

- What is a Health Reimbursement Account (HRA);
- Who is eligible and how to enroll;
- How the HRA works;
- Claim procedures and requesting reimbursement from your HRA.
- HRA Glossary

Notice to Employees

This section of the Summary Plan Description (SPD) describes the Employer-sponsored Health Reimbursement Account (HRA).

City of Dallas has entered into an agreement with UnitedHealthcare Services, Inc., Hartford, CT, ("UnitedHealthcare") under which UnitedHealthcare will process eligible healthcare expense reimbursements through the HRA and provide certain other administrative services pertaining to the Plan. UnitedHealthcare does not insure the benefits described in this section.

Quick Reference Box

- Member services and claim inquiries, use the Customer Service number on the back of your ID card or call 1-800-645-6555;
- UnitedHealthcare HRA Claims submittal address: UnitedHealthcare – HRA Group Claims, P.O. Box 981178, El Paso, TX 7998-1178; and
- Online assistance: **www.myuhc.com**

WELCOME - HRA

This section of your Summary Plan Description (SPD) describes the Health Reimbursement Account (HRA) available to you and your eligible dependents enrolled in the Plan.

A Health Reimbursement Account is a financial account that allows City of Dallas to reimburse you for health expenses paid by you, under the associated medical plan, to offset health care costs.

It is your responsibility to manage your HRA account balance. We offer several tools to help you; refer to Section 7 – Resources to Help You Stay Healthy for information on health and well-being resources available to you, or visit **www.myuhc.com** for access to a treatment cost estimator. Once you spend your entire HRA balance, you are responsible for paying expenses as described in your SPD.

You can keep track of the funds in your HRA by going online to **www.myuhc.com**, by calling the toll-free number on the back of your ID card or by checking your monthly member statement sent to you by UnitedHealthcare.

Please read this section thoroughly to learn how the HRA component of the Plan works. If you have questions call the number on the back of your ID card. Capitalized terms not otherwise defined in this section have the meaning set forth in the SPD, Section 14 – Glossary.

What is a Health Reimbursement Account?

Health Reimbursement Accounts are "unfunded" accounts; otherwise known as a demand deposit account. City of Dallas is not required to prepay into it, instead, funds allocated to the HRA are made available to reimburse you for claims as they occur. All contributions allocated to your HRA are owned, controlled and payable solely from the general assets of City of Dallas. You are not permitted to make any contribution to the HRA, whether made on a pre-tax or after-tax basis. In addition:

- The HRA is established by City of Dallas and administered by UnitedHealthcare in accordance with applicable provisions of the Internal Revenue Service Code and associated guidance issued by the IRS/Treasury Department.
- City of Dallas determines which Internal Revenue Code 213d health expenses will be eligible for reimbursement through the HRA.
- There is no limit to the contributions City of Dallas can choose to allocate to your account.
- Employer Contributions allocated to your HRA can be excluded from your gross income.
- City of Dallas will decide how to handle unused funds at the end of the calendar year. Unused funds are not transferable if your employment with City of Dallas ends.
- You can participate in an HRA and a Flexible Spending Account (FSA) at the same time. However, City of Dallas will determine the order under which claims may be reimbursed from the HRA or FSA.

INTRODUCTION - HRA

Who Is Eligible for the HRA And How To Enroll

You must be covered under a medical plan in order to participate in the HRA. You are enrolled in the HRA at the same time you enroll in your medical plan. You cannot elect it separately and you can't withdraw from it unless you also withdraw from the medical plan. Eligibility to participate in the Plan is described in the SPD, section 2 –Introduction. Contact City of Dallas Benefit Service Center if you have questions about eligibility and enrollment.

Each year during annual Open Enrollment, you have the opportunity to review and change your benefit election. Any changes you make during Open Enrollment will become effective as described in the SPD, section 2 –Introduction.

Important
If you wish to change your benefit elections following a marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact City of Dallas Benefit Service Center as described in the medical plan SPD, section 2 – Introduction under the heading *Changing You Coverage.* Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

Cost of Coverage

You and City of Dallas share in the cost of the medical plan, there is no charge to you for participation in the financial account component of your Plan. Your contribution amount, (also known as a premium) depends on the medical plan you select and the family members you choose to enroll.

Your medical plan premium is deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. For more information on the Cost of Coverage please refer to the SPD, section 2 –Introduction under the heading *Cost of Coverage.*

Changing Your HRA Coverage

If you are hired during the Plan year or are enrolling in the Plan mid-year during a special enrollment period, coverage will become effective as described in the SPD, section 2 – Introduction under the heading *Changing Your Coverage.*

For detail on the Employer Contribution to your HRA for mid-year enrollment and/or status changes see this Section 17 – Health Reimbursement Account under heading *How the Plan Works*, and look for "New Hires and Adjustments for Status Changes".

For information on ending your coverage please refer to this Section 17 –Health Reimbursement Account of the SPD, under the header *When HRA Coverage Ends.*

HOW THE HRA WORKS

How much money is allocated to your HRA – Employer Contributions

City of Dallas will allocate a specified amount of funds to your HRA on a calendar year basis specific to the coverage category you enroll in. For each claim presented to the HRA, available funds will be used to pay for Eligible Medical Expenses. The table below contains the details for the Employer Contribution to your HRA:

Coverage Category	Annual Employer Contribution to your HRA[1]
1.Employee Only or	$700*
2.Family	$1,700*

[1]This is the only amount that will be placed in your HRA during the calendar year and may be used for Eligible Expenses.

* Employees who complete a Health Assessment online @ www.myuhc.com between January 1, 2011 and February 28, 2011 will be awarded an additional $300 dollars.

New Hires And Adjustments For Status Changes

Mid-Year Enrollment

If you are hired during the Plan year or are enrolling in the Plan mid-year during a special enrollment period as a result of a change in status, the amount of the Employer Contribution allocated to your HRA will be prorated on a monthly basis, effective retroactive to the first day of the month in which you are enrolled in the Plan.

Status Changes

When you switch among Coverage Categories the City of Dallas' contribution amount allocated to your HRA may increase or decrease by category.

Under the Plan, if you increase your category (e.g. self to self plus family) the Employer Contribution to your HRA is adjusted to your new category for that Plan year minus any amounts already accumulated or used in that Plan year.

If you decrease your category (e.g. you change from self plus family to self) the Employer Contribution to your HRA is *not* adjusted to your new category for that Plan year.

Rehires

If during a Plan year, you are enrolled in an active medical plan as described in your medical plan SPD and you are rehired by City of Dallas following your employment termination date and re-enroll in the active medical Choice HRA plan, City of Dallas will allocate the HRA Contribution amount equal to the amount a newly hired active employee would be eligible for. (See this section under the heading *Mid-Year Enrollment.*)

You can keep track of the funds in your HRA by going online to **www.myuhc.com**, by calling the toll-free number on the back of your ID card or by checking your monthly member statement sent to you by UnitedHealthcare.

What Expenses Are Payable From Your HRA

The HRA reimburses all amounts due from claims for medical expenses that are eligible from the underlying medical plan, plus any claims for pharmacy expenses. Eligible expenses include Annual Deductible, Coinsurance and Copayments.

Order of Accounts

If you choose to participate in multiple spending accounts be aware that a payment hierarchy does exist. The order in which your accounts must be used for reimbursements is described in the table below:

Account	Hierarchy Order Of Accounts
1. FSA Grace Period	First
2. Health Reimbursement Account (HRA)	Second
3. FSA	

While the HRA and FSA may cover some of the same types of expenses, the FSA may be funded with pre-tax contributions under a salary reduction arrangement.

Expenses reimbursed through the HRA cannot also be reimbursed through the FSA.

What Happens to Remaining Balances in the HRA?

If you don't spend all the funds in your HRA during the initial calendar year, and you re-enroll in the HRA for the following year, any remaining HRA balance up to $6,000 rolls over into your account for the next calendar year. In this manner your HRA may "grow" almost like a savings account.

If you don't re-enroll in the HRA for the following year, you forfeit any unused funds remaining in the account.

CONSUMER ACCOUNTS MASTERCARD® CARD

Consumer Accounts MasterCard® Card

The Consumer Accounts Card is a payment mechanism that allows members a means for direct payment of Eligible Expenses, per your specific plan design described under section, Your HRA, to UnitedHealthcare network providers, Drugstore.com, Walgreen's and participating merchants. Payment for Eligible Expenses comes directly from your HRA and eliminates the need for most paper claims. You will be provided with two Consumer Accounts Cards, with terms and conditions and activation information that may be used at certain locations where MasterCard® is accepted. Contact the customer service number listed on the back of the Consumer Accounts Card with questions or to request additional cards.

Use of the Consumer Accounts Card is voluntary. The card must be activated prior to use. When you activate the Consumer Accounts Card:

1.Prior to the plan effective date, wait one (1) business day after the plan effective date before you utilize your card;

2. After the plan effective date, the card will be ready to use one (1) business day following activation.

UnitedHealthcare Network Providers and Participating Merchants

The consumer website, www.myuhc.com, contains a directory of medical, dental and vision providers in UnitedHealthcare's provider network. While network status may change from time to time, www.myuhc.com has the most current source of provider network information. Use myuhc.com to search for network providers available in your specific plan design.

Participating drug store and pharmacy merchants comply with specific methods used to identify and substantiate eligible expenses, per the United States Internal Revenue Code of 1986 ("IRC"), as amended from time to time. You can see a full list of participating merchants at http://www.sig-is.org. Participating merchants identify what is an eligible expense under 213d of the IRC, they do not identify eligible HRA expenses at point of sale based on your specific plan design.

Using the Consumer Accounts Card

The Consumer Accounts Card may not be used at point of sale to make a purchase from non-participating merchants. You will need to pay using another form of payment, and then submit eligible expense receipts for reimbursement as described under the section, Requesting Reimbursement from your HRA.

The Consumer Accounts Card may be used for a point of sale purchase at any UnitedHealthcare network provider or participating merchant with a Point-of-Service (POS) bankcard terminal that accepts MasterCard® such as a network hospital, network physician and retail network pharmacy counters.

You may choose to use your Consumer Accounts Card for mail order prescriptions or for over-the-counter items by going to an online pharmacy at Drugstore.com via myuhc.com.

Additionally, your Consumer Accounts Card can be used at Walgreen's retail stores or at participating drug store and pharmacy merchants.

No Personal Identification Number ("PIN") is required when you use the Consumer Accounts Card. At the point of sale choose 'credit' on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your HRA and card are regulated by the Internal Revenue Service, therefore you should retain all itemized receipts generated from the Consumer Accounts Card. Certain payments must be verified and UnitedHealthcare may request this receipt from you to ensure that payment was made for a qualified HRA expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the Consumer Accounts Card through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases in real-time and automatically debits your HRA account based on the guidelines established by the IRS and your specific plan design as described under section, Your HRA. A claim number is assigned to the transaction.

Partial Payment Authorization

Partial authorization capability allows you to use your Consumer Accounts Card with transactions amounts greater than the funds available in your HRA for a portion of the transaction at merchants that accept partial authorization. For example, if you purchase an item that costs $20 and you only have $10 remaining in your HRA, the HRA balance of $10 will be authorized towards the purchase and you are responsible for paying the remaining balance of $10 with another form of payment. Note: not all merchants accept partial authorization.

Member Health Statements and HRA Yearly Statements

Member Health Statements are available on the consumer website, myuhc.com. A member health statement is produced whenever there is claims activity for a member. You will receive monthly health statements and a HRA yearly statement which will include your card activity. If you note a discrepancy with a card transaction, call the number on the back of your Consumer Accounts Card to resolve the issue.

HRA CLAIM PROCEDURES

Claims Submission

City of Dallas has designed your HRA to allow certain claims to be automatically submitted to your account for reimbursement. UnitedHealthcare will coordinate payments from your HRA for medical and pharmacy claims.

You can turn this feature "off" or back "on" via myuhc.com.

There are some types of claims that will not be processed automatically for which you will need to submit a claim; for additional information on these claims see the header below called When to Submit a Claim.

When auto-submission is elected all payments from an HRA will be sent to the provider directly. You will receive the reimbursement when no provider information is available. In the situations listed below, you will receive reimbursement from the HRA:

1. Pharmacy claims
2. Copays
3. Manually submitted claims
4. Claims adjustments

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will process the payment for the medical plans portion of the cost of the Covered Health Services and send it directly to the Physician or facility.

Funds allocated to your HRA will be available to help you pay a portion of your out-of-pocket costs under the medical plan as described in this SPD in Section 3 How the Plan Works. UnitedHealthcare will process the payment for a portion of your cost of the Covered Health Services from available funds in your HRA and send it directly to the Physician or facility automatically. This feature can be turned on and off by accessing myuhc.com. There are some types of claims that will not be paid directly to the provider, they are as follows: Pharmacy Claims, Copays, manually submitted claims, and adjustments and out of network provider claims. These types of claims will always pay you directly.

When to Submit a Claim

You must submit a claim for reimbursement from your HRA for any other types of expenses other than Covered Health Services and any health expenses not submitted to UnitedHealthcare.

If you receive a bill for Covered Health Services from a provider, you 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 HRA Claims submittal address:

UnitedHealthcare – HRA Group Claims
P.O. Box 981178
El Paso, TX 7998-1178

Important - Timely Filing of Claims
All claim forms must be submitted within 90 days 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 City of Dallas. This 90 day requirement does not apply if you are legally incapacitated.

How to File Your Claim

To be reimbursed from your HRA simply submit a reimbursement form, called a Reimbursement Request for Withdrawal Form, for the Eligible Expenses that have been incurred. A Request for Withdrawal Form is available from City of Dallas or on the Internet at **www.myuhc.com**. For reimbursement from your HRA, you must include proof of the expenses incurred. For Eligible Medical Expenses, proof can include a bill, invoice, or an Explanation of Benefits (EOB) from any group medical/dental plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical and dental plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental plans.

Important
You can view EOB's and Health Statements online via myuhc.com. Myuhc.com includes many features such as the option to:

- View your HRA summary page detailing contributions and amount left in your HRA;
- View your HRA Claims Summary including claim transaction details.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. 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 paper copies of the

EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **myuhc.com**. See section 14, *Glossary* for the definition of Explanation of Benefits.

Requesting Reimbursement from Your HRA

If you have funds available in your HRA you may submit a claim for reimbursement for the Eligible Expenses from your HRA. If you do choose to submit a request for reimbursement, the request must be received no later than 90 days following the end of the calendar year in which you are eligible under this Plan. If you don't provide this information to the Claims Administrator within this timeframe, your claim will not be eligible for reimbursement, even if there are funds available in your HRA. This time limit does not apply if you are legally incapacitated.

You cannot be reimbursed for any expense paid under your medical plan. Expenses for which you are reimbursed from your HRA cannot be included as a deduction or credit on your federal income tax return.

Important Note

- The date on which you incurred an eligible medical expense is the date used when deducting amounts from your HRA. This allows your HRA to act like a savings account, available for your use when your claim is paid.

Claims for Reimbursement and Appeals

To be reimbursed from your HRA simply submit a reimbursement form, called a Request for Withdrawal Form, for the eligible expenses that have been incurred. A Request for Withdrawal Form is available from City of Dallas or on the Internet at **www.myuhc.com**. For reimbursement from your HRA, you must include proof of the expenses incurred as indicated on the Request for Withdrawal Form. For eligible expenses, proof can include a bill, invoice, or an Explanation of Benefits (EOB) from any group medical/dental plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical plans.

When filing a claim for reimbursement from your HRA, your claims should be submitted to:

UnitedHealthcare – HRA Group Claims
P.O. Box 981178
El Paso, TX 7998-1178;

Important
You can view EOB/member statements online via myuhc.com. Myuhc.com includes many features such as the option to:

- View your HRA summary page detailing contributions and amount left in your HRA;
- View your HRA Claims Summary including claim transaction details.

For additional information on claims procedures and appeals, please refer to section 9, *Claims Procedures.*

HRA COORDINATION OF BENEFITS (COB)

For information on how your Benefits under this Plan coordinate with other medical plans and how coverage is affected if you become eligible for Medicare, refer to section 10 – Coordination of Benefits (COB).

Overpayment and Underpayment of Benefits

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan. For further information on COB refer to section 10 – Coordination of Benefits (COB).

SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement, as defined in the SPD section 11 – Subrogation and Reimbursement.

WHEN HRA COVERAGE ENDS

Your coverage under the Plan ends as described in the SPD, section 12 – When Coverage Ends.

Continuation of Coverage - Consolidated Omnibus Budget Reconciliation Act ("COBRA")

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the Health Reimbursement Account. You should call City of Dallas to find out whether this Plan is subject to COBRA. If the Plan is subject to COBRA see "Optional Continuation Coverage under your Health Care Spending Account (COBRA)".

COBRA continuation coverage must be offered with respect to a participant's HRA when the Plan is subject to COBRA. If your employment terminates for any reason the funds in your HRA will revert back to us after your claim run-out period, unless you elect COBRA coverage as described in the SPD, section 12 –When Coverage Ends under the heading *Changing You Coverage.* If you elect COBRA coverage, HRA funds will remain available to assist you in paying your out-of-pocket costs under the medical plan while COBRA coverage is in effect. The HRA balances under COBRA are recalculated using the methods elected by City of Dallas for mid-year enrollment and/or status changes; as described in Section 17 – Health Reimbursement Account under heading *How the Plan Works*, and look for "New Hires and Adjustments for Status Changes".

GLOSSARY

What this section includes:

- Definitions of terms used throughout this Section 17.

Many of the terms used throughout this Attachment 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 Attachment, but it does not describe the benefits provided by the Plan. Capitalized terms not otherwise defined in this section have the meaning set forth in your medical plan SPD.

HRA - Health Reimbursement Account or HRA. It is an IRS section 105 and 106 account that follows standard regulations and tax benefits for such accounts. It can only be used for qualified medical expenses.

HRA ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the HRA portion of the Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional information can be found in this SPD, section 16 Plan Administrative Information.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the HRA Plan Benefits described in this Summary Plan Description.

UnitedHealthcare Services, Inc.
185 Asylum Street.
Hartford, CT 06103-3408

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

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

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

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

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

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

> ***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 Summary Plan Description (see Section 5, *Plan Highlights*) 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 Dependents as defined in the Summary Plan Description in Section 14, *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 the number on the back of your ID card.

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 ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your 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 the toll-free phone number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description 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 people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

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 insurance plan for Covered Health Services described in the Summary Plan Description 5, *Plan Highlights*) 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 your health 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 receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *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 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps facilities and clinics online based on location, compare 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 even work with a single 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 via phone (toll-free) by calling 1-866-774-4626.

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 1-877-801-3507 (toll-free).

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Summary Plan Description

City of Dallas
Pre-65 Retiree
Choice

Effective: January 1, 2013
Group Number: 708872

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: (800) 846-4678;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, Utah 84130-0555; and
- Online assistance: **www.myuhc.com**.

City of Dallas is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- 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.

City of Dallas 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. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. City of Dallas is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the City of Dallas Health Plan works. If you have questions contact City of Dallas Benefits Service Center at 1-888-752-9122 or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can request printed copies of the SPD by contacting City of Dallas Benefit Service Center.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary.*
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary.*
- City of Dallas is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

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 enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time or permanent part-time Participant who is scheduled to work at least 20 hours per week or a person who retires while covered under the Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, (including Domestic Partner), as defined in Section 14, *Glossary*;
- you or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian or a tax dependent grandchild;
- a child age 26 or over who is or becomes disabled and dependent upon you; and
- certain survivors (see Survivorship Coverage in Section 12, *When Coverage Ends*)

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the City of Dallas Benefit Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the City of Dallas Benefit Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information.*

Cost of Coverage

You and City of Dallas share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld -

and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of City of Dallas' cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and the City Council reserves the right to change contributions required by the Plan.

You can obtain current contribution rates by calling City of Dallas Benefit Service Center at 1-888-752-9122.

How to Enroll

To enroll, call City of Dallas Benefit Service Center at 1-888-752-9122 within 30 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 30 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1. Retirees who previously waived coverage cannot re-enroll.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact City of Dallas Benefit Service Center within 30 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once City of Dallas Benefit Service Center receives your properly completed enrollment, coverage will begin on your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first of the month following the date City of Dallas Benefit Service Center receives notice of your marriage, provided you notify City of Dallas Benefit Service Center within 30 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify City of Dallas Benefit Service Center within 30 days of the birth, adoption, or placement.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- registering a Domestic Partner;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact City of Dallas Benefit Service Center within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact City of Dallas Benefit Service Center within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact City of Dallas Benefit Service Center within 30 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status 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 above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical 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.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Out-of-Pocket Maximum;
- Coinsurance.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Network Physician or health care professional you prefer each time you need to receive Covered Health Services.

You are eligible for Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. Except as specifically described within the SPD benefits are not available for services provided by a non-Network provider.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services and Covered Health Services received at an Urgent Care Center outside your geographic area are always paid as Network Benefits.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a 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. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of City of Dallas or UnitedHealthcare.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will not be paid.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

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

Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition in Section 14, *Glossary*. For certain Covered Health Services, the Plan will not pay these expenses until you have met your Annual Deductible. City of Dallas has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a Network provider. If you do not show your ID card, a Network provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

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

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

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. Copays do not count toward the Out-of-Pocket-Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance - Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 70%, you are responsible for paying the other 30%. This 30% is your Coinsurance.

Out-of-Pocket Maximum

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

The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

Plan Features	Applies to the Out-of-Pocket Maximum?
Copays	No
Payments toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for non-Covered Health Services	No

SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact 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 you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components and notification requirements are subject to change without notice. As of the publication of this SPD, the Personal Health Support 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 a certain chronic or complex condition, 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 toll-free number on your ID card.

Requirements for Notifying Personal Health Support

In most cases, Network providers are responsible for notifying Personal Health Support before they provide these services to you. However, you are responsible for notifying the Personal Health Support staff prior to receiving a service for:

- dental services - accident only;
- obesity surgery; and
- transplantation services.
- Cancer Resource Services
- Kidney Resouce Services
- Reconstructive Procedures

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB).*

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of the coinsurance percentage or Copayment amount that applies when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network
Copays	
■ Emergency Health Services	$100
Annual Deductible[2]	
■ Individual	$3,000
■ Family (not to exceed $3,000 per Covered Person)	$9,000
Annual Out-of-Pocket Maximum[2]	
■ Individual	$7,500
■ Family (not to exceed $7,500 per Covered Person)	$15,000
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited

[1]In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.

[2]Copays do not apply toward the Annual Deductible or Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details.*

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Acupuncture Services	70% after you meet the Annual Deductible
Ambulance Services ■ Emergency Ambulance	70% after you meet the Annual Deductible
Cancer Resource Services (CRS) ■ Hospital Inpatient Stay	70% after you meet the Annual Deductible
Congenital Heart Disease (CHD) Surgeries	70% after you meet the Annual Deductible
Dental Services - Accident Only	70% after you meet the Annual Deductible
Diabetes Services ■ Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 15, *Prescription Drugs.*
Durable Medical Equipment (DME)	70% after you meet the Annual Deductible
Emergency Health Services - Outpatient Emergency services received at a non-Network Hospital are covered at the Network level. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	*Emergency Room Facility* 100% after you pay a $100 Copay *All other Services Required in Emergency Room* 70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Extreme Vision	70% after you meet the Annual Deductible
Hearing Aids	70% after you meet the Annual Deductible
Home Health Care Up to 30 visits per calendar year	70% after you meet the Annual Deductible
Hospice Care	70% after you meet the Annual Deductible
Hospital - Inpatient Stay	70% after you meet the Annual Deductible
Kidney Resource Services (KRS) (These Benefits are for Covered Health Services provided through KRS only)	70% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics – Outpatient	70% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	70% after you meet the Annual Deductible
Mental Health Services ■ Hospital - Inpatient Stay ■ Physician's Office Services	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Neonatal Resource Services (NRS) (These Benefits are for Covered Health Services provided through NRS only)	70% after you meet the Annual Deductible
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders ■ Hospital - Inpatient Stay ■ Physician's Office Services	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Nutritional Counseling	70% after you meet the Annual Deductible
Obesity Surgery ■ Physician's Office Services ■ Physician Fees for Surgical and Medical Services ■ Hospital - Inpatient Stay See Section 6, *Additional Coverage Details* for limits	70% after you meet the Annual Deductible
Ostomy Supplies	70% after you meet the Annual Deductible
Pharmaceutical Products – Outpatient See Section 6, *Additional Coverage Details*	70% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	70% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	70% after you meet the Annual Deductible
Pregnancy - Maternity Services ■ Physician's Office Services ■ Hospital - Inpatient Stay ■ Physician Fees for Surgical and Medical Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	100% 70% after you meet the Annual Deductible 70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Preventive Care Services ■ Breast Pumps ■ Physician Office Services ■ Lab, X-ray or Other Preventive Tests	100% Deductible does not apply 100% Deductible does not apply 100% Deductible does not apply
Private Duty Nursing - Outpatient Up to 30 visits per calendar year	70% after you meet the Annual Deductible
Prosthetic Devices	70% after you meet the Annual Deductible
Reconstructive Procedures ■ Physician's Office Services ■ Hospital - Inpatient Stay ■ Physician Fees for Surgical and Medical Services ■ Prosthetic Devices ■ Surgery - Outpatient	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible 70% after you meet the Annual Deductible 70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits	70% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	70% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 120 days per calendar year	70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Substance Use Disorder Services ■ Hospital - Inpatient Stay ■ Physician's Office Services	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Surgery – Outpatient	70% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	70% after you meet the Annual Deductible
Therapeutic Treatments – Outpatient	70% after you meet the Annual Deductible
Transplantation Services (If services rendered by a Designated Facility)	70% after you meet the Annual Deductible
Travel and Lodging (If services rendered by a Designated Facility)	For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment or transplant procedures
Urgent Care Center Services	70% after you meet the Annual Deductible
Wigs Up to $300 per calendar year	70% after you meet the Annual Deductible

[1]In general, your Network provider must notify Personal Health Support, as described in Section 4, before you receive certain Covered Health Services. There are some Network Benefits, however, for which you are responsible for notifying Personal Health Support. See Section 6, *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services -Sickness and Injury*, *Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Lab, X-Ray and Diagnostics - Outpatient*, and *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call Personal Health Support.

This section supplements the second table in Section 5, *Plan Highlights.*

While the table provides you with benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions.*

Acupuncture Services

The Plan pays for acupuncture services for pain therapy when both of the following are true:

- another method of pain management has failed; and
- the service is performed by an MD in the provider's office.

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 14, *Glossary* for the definition of Emergency.

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

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in Section 14, *Glossary.*

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or

- visit www.urncrs.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits for Network services 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.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Facility.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include 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
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, 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.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Dental Services - Accident Only

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

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from 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 occurs 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 Injury and if extenuating circumstances exist due to the severity of the Injury.)

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:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

- 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; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Please remember that you should notify Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment.

Diabetes Services

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

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.
Diabetic Self-Management Items	Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 15, *Prescription Drugs*.

Durable Medical Equipment (DME)

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

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in 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. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- burn garments;
- filters for sleep apnea machines;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, including 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 orthotic devices and 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 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. Benefits are limited as stated below.

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

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

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

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including 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 anytime and are not subject to the three year timeline for replacement.

Emergency Health Services - Outpatient

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

If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, no Benefits will be paid.

Extreme Vision

The Plan's pays for Benefits for the following:

- necessary contact lenses or eyeglasses to correct vision problems following cataract surgery; and

- evaluation, fitting cost and purchase cost of contact lenses if there is a diagnosis of Karatoconus.

Benefits are limited to once every 12 months.

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 do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons 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.

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 in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, intermittent schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

Personal Health Support 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" simply because there is not an available caregiver.

Benefits are limited to 30 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital 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.*

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

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined in Section 14, *Glossary.*

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

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by Personal Health Support; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, 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.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include, but are not limited to:

- lab and radiology/x-ray; and
- mammography.

Benefits under this section include:

- 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.* Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services 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:

- 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.*

Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services; and
- crisis intervention.

Benefits include the following ser vices provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

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. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. 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 Covered Person and is not mandatory.

Please remember you should notify UnitedHealthcare, the MH/SUD Administrator, to receive these Benefits in advance of any treatment. Please call the phone number that appears on your ID card.

Neonatal Resource Services (NRS)

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated Facilities participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. Designated Facility is defined in Section 14, *Glossary.*

In order to receive Benefits under this program, the Network provider must notify NRS or Personal Health Support if the newborn's NICU stay is longer than the mother's hospital stay.

You or a covered Dependent may also:

- call Personal Health Support; or
- call NRS toll-free at (888) 936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, 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.

Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders

The Plan pays Benefits for psychiatric services for Autism Spectrum 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 or property and impairment in daily functioning.

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

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provided-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care with regard to services for Autism Spectrum Disorder. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Please remember you should notify UnitedHealthcare, the MH/SUD Administrator, to receive the Benefits for Autism Spectrum Disorder in advance of any treatment. Please call phone number that appears on your ID card.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional for Covered Persons with diabetes that require a special diet.

Obesity Surgery

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician.

Morbid obesity means morbid or clinically severe obesity correlated with a Body Mass Index (BMI) of 40 kg/m2 or with being 100 pounds over ideal body weight and 30% over ideal body weight with underlying medical conditions

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Surgery is limited to a lifetime benefit of $5,000. There is no calendar year limit for non-surgical treatment.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Physician Fees for Surgical and Medical Services

The Plan pays 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 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 allergy injections and hearing exams in case of Injury or Sickness.

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

Pregnancy - Maternity Services

Employee and Dependent Spouse Only

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for postnatal care, delivery, and any related complications.

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 Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

For Dependent Children Only

Pregnancy Benefits for Dependent children are limited to Covered Health Services for Complications of Pregnancy. For a complete definition of Complications of Pregnancy, see Section 14, *Glossary*.

Benefits are payable for Covered Health Services for the treatment of Complications of Pregnancy given to a Dependent child while covered under this Plan.

Benefits for Complications of Pregnancy are paid in the same way as benefits are paid for Sickness.

Benefits for Complications of Pregnancy which result in the delivery of a child are payable for at least:

- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery; and
- 96 hours of inpatient care for the mother and newborn child following a cesarean section.

The following are not considered Complications of Pregnancy:

- false labor;
- occasional spotting;
- rest prescribed by a Physician;

- morning sickness; and
- other conditions that may be connected with a difficult pregnancy but are not a classifiably distinct complication.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

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

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

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Benefits are limited to 30 visits per Covered Person per calendar year.

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 provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

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 would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. 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.

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. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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 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 the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the

appearance of a body part. Cosmetic procedures are excluded from coverage. 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 14, *Glossary*.

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

Please remember that you should notify Personal Health Support five business days before undergoing a Reconstructive Procedure. When you provide notification, Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Benefits are limited to:

- 20 visits per calendar year for physical therapy;
- 20 visits per calendar year for occupational therapy;
- 20 visits per calendar year for speech therapy;
- 20 visits per calendar year for Manipulative Treatment.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays 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 those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

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

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 arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

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, including anesthesiologists, consulting Physicians, pathologists and radiologists, are described in this section under *Physician Fees for Surgical and Medical Services.*

UnitedHealthcare 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
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

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

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons 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 14, *Glossary*.

Benefits are limited to 120 days per calendar year.

Substance Use Disorder Services

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

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management;
- crisis intervention; and
- detoxification (sub-acute/non-medical).

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

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. The Substance Use Disorder Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use 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 Covered Person and is not mandatory.

Please remember you should notify UnitedHealthcare, the MH/SUD Administrator, to receive these Benefits in advance of any treatment. Please call phone number that appears on your ID card.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

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

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

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

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 arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *U.S. Food and Drug Administration (FDA)*-approved TMJ implants only when all other treatment has failed.

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.

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 healthcare professionals when:

- education is 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.

Benefits under this section include:

- 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.*

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network provider and received at a Designated Facility. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. 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 that are provided by a Network provider at a Network Hospital. You are not required to notify United Resource Networks or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

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.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the telephone number on your ID card for information about these guidelines.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Facility.

Travel and Lodging

United Resource Networks or Personal Health Support will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD);
- transplantation services; and
- cancer-related treatments.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment, the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $75 per day for the patient or up to $100 per day for the patient plus one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility (for CRS and transplantation) or the CHD facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

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.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *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.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis regardless of the reason of hair loss.

Benefits are limited to $300 per calendar year.

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

City of Dallas believes in giving you the tools you need to be an educated health care consumer. To that end, City of Dallas has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
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 own health. UnitedHealthcare and City of Dallas 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 text.

Consumer Solutions and Self-Service Tools

Employee Assistance Program (EAP)

UnitedHealthcare offers free counseling and referral services nationwide through the Employee Assistance Program (EAP). Using a solution focused approach to care, they tailor their interventions to meet your individual needs. The program can help you and your immediate family members cope with issues such as:

- family or relationship problems;
- parenting difficulties;
- work-related problems;
- financial and legal issues;
- substance use or abuse;
- grief and loss; and
- anxiety.

Call the toll-free phone number on the back of your ID card to speak to a specially trained, master's-level specialist who will recommend the right resources for your specific life

concern. Services are available any time, 24 hours a day, seven days per week and are strictly confidential in accordance with state and federal laws.

Health Assessment

You are invited to learn more about your health and wellness at **www.myuhc.com** 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.

To find the health assessment, log in to **www.myuhc.com**. 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 the number on the back of your ID card.

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;
- smoking 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 – City of Dallas' way of helping you meet your health and wellness goals.

NurseLine℠

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. 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 City of Dallas 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 in Spanish.

NurseLine is available to you at no cost.

Note: If you have a medical emergency, call 911 instead of calling NurseLine.

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. 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** 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 logging onto **www.myuhc.com**.

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 the number on the back of your ID card.

UnitedHealth Premium℠ Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium 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 and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- 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;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;

- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** 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 Physician.

Disease and Condition Management Services

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 even 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 and 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 the number on the back of your ID card.

HealtheNotes℠

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

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

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

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

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. 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 the toll-free number on the back of your ID card.

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.

SECTION 8 - 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, *Additional Coverage Details.*

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights.* Limits may also 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, *Plan Highlights.* Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

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

Alternative Treatments

1. acupressure
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. Rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details.*

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

   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. Examples include treatment

of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

   - extractions (including 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 accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details.*

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

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details.*

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

   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 for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details.*

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

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, *Additional Coverage Details*.

   Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter.

3. cranial banding;

4. the following items are excluded, even if prescribed by a Physician:

   - blood pressure cuff/monitor;
   - enuresis alarm;

- non-wearable external defibrillator;
- trusses;
- ultrasonic nebulizers;

5. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

6. the replacement of lost or stolen prosthetic devices;

7. 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, *Additional Coverage Details* ; and

8. oral appliances for snoring.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the prescription portion of the Plan, which is administered by Caremark. Please visit **www.caremark.com** or call the number on your ID Card for more information.

1. Prescription Drugs for outpatient use that are filled by a prescription order or refill;

2. self-injectable medications (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);

3. growth hormone therapy;

4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and

5. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *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.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

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

2. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet;
   - 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;

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. treatment of flat feet;

4. shoe inserts;

5. arch supports;

6. shoes (standard or custom), lifts and wedges; and

7. shoe orthotics.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

   - elastic stockings, ace bandages, diabetic strips, and syringes; and
   - urinary catheters.

   This exclusion does not apply to:

   - ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*; or
   - diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, Additional Coverage Details.

2. 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; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details.*

Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders* [2]and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details.*

1. services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that , in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:

3. not consistent with generally accepted standards of medical practice for the treatment of such conditions;

4. not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;

5. not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or

6. not clinically appropriate for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

7. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

8. Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;

9. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal);

10. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;

11. tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act;

12. learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

13. mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

14. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction; and

15. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

1. nutritional or cosmetic therapy using high dose 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*, and except as defined under *Nutritional Counseling* in Section 6, *Additional Coverage Details*;

3. food of any kind. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are the only source of nutrition and even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - foods to control weight, treat obesity (including 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 and electrolyte supplements; and

4. 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. supplies, equipment and similar incidentals for personal comfort. Examples include:

   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - electric scooters;
   - 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; and
   - home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and

- replacement of an existing intact 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, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;

4. treatment of benign gynecomastia (abnormal breast enlargement in males).

Preexisting Conditions

1. Benefits for the treatment of a Preexisting Condition are excluded unless you have had Continuous Creditable Coverage for 12 months. Preexisting Condition is defined in Section 14, *Glossary*.

   This exclusion does not apply to Covered Persons under age 25.

Procedures and Treatments

1. biofeedback;

2. 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);

3. rehabilitation services and Manipulative 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;;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

8. psychosurgery (lobotomy);

9. treatment of tobacco dependency;

10. chelation therapy, except to treat heavy metal poisoning;

11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, such as asthma or allergies;

12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

13. sex transformation operations;

14. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*;

15. medical and surgical treatment of hyperhidrosis (excessive sweating);

16. the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations;

17. upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor or cancer. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment, except as treatment of obstructive sleep apnea; and

18. breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details.*

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

   - prior to ordering the service; or
   - after the service is received.

   This exclusion does not apply to mammography testing.

Reproduction

1. health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment

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

2. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);

3. surrogate parenting, donor eggs, donor sperm and host uterus;

4. the reversal of voluntary sterilization;

5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

6. prenatal, labor and delivery coverage for enrolled Dependent children except those that have Complications of Pregnancy as defined in Section 14, *Glossary*;

7. fetal reduction surgery;

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

   This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

9. contraceptive supplies and services (certain contraceptives are covered at 100%, not subject to the Annual Deductible, per Health Care Reform. Contact UnitedHealthcare for additional information);

10. services provided by a doula (labor aide); and

11. parenting or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);

3. transplants that are not performed at a Designated Facility (this exclusion does not apply to cornea transplants); and

4. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary;*

3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

4. Private Duty Nursing received on an inpatient basis;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in Section 6, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants; and

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;

2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

3. purchase cost and associated fitting charges for eyeglasses or contact lenses;

4. bone anchored hearing aids except when either of the following applies:

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

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

5. eye exercise or vision therapy; and

6. 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; or

- 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; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

   - that do not meet the definition of a Covered Health Service in Section 14, *Glossary*;
   - that 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 Covered Persons 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 which 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 Benefit Plan; or
   - that exceed Eligible Expenses or any specified limitation in this SPD;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; and

8. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - required solely for purposes of education, sports or camp, insurance, marriage or adoption; or as a result of incarceration;
   - conducted for purposes of medical research;
   - related to judicial or administrative proceedings or orders; or
   - required to obtain or maintain a license of any type.

9. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

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

Network Benefits

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 the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and 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 Benefits

If you receive a bill for Covered Health Services from a non-Network provider as a result of an Emergency, 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 address on the back of your ID card.

Prescription Drug Benefit Claims

Prescription coverage is available through Caremark. For information on submitting your outpatient prescription drug claims, call the toll-free number on your ID Card or visit **www.caremark.com**.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting City of Dallas Benefit Service Center. 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 patient's name, age and relationship to the Participant;
- the number as shown on your 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 carrier(s).

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

The above information should be filed with us at the address on your ID card. After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the 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 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, your provider, and not to a third party, even if your provider has assigned Benefits to that third party.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. 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 paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Claims
All claim forms must be submitted within 90 days 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 City of Dallas. This 90 day 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 the number on your ID card 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, post-service claim or a rescission of coverage determination as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the 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 request.

You or your enrolled Dependent may send a written request for an appeal to:

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

Customer Service: 800-736-1364

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card 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;
- post-service claim; or
- concurrent claim.

Review of an 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 will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from City of Dallas within 60 days from receipt of the first level appeal determination. City of Dallas must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. City of Dallas will review all claims in accordance with the rules established by the U.S. Department of Labor. City of Dallas's decision will be final.

Federal External Review Program

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

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

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or

- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card 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 received City of Dallas' decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; 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; and
- a decision by the IRO.

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

- is or was covered under the 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 a notification in writing to you. 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.

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 of receipt of the notice additional information that the IRO will 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.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making City of Dallas' determination. The documents include:

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

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by City of Dallas. 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 they request 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 City of Dallas' determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. 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.

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 individual or would jeopardize the individual'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 timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual'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 individual received emergency services, but has not been discharged from a facility.

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

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

After UnitedHealthcare completes 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 City of Dallas. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and

- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
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** after receiving an extension notice*
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
City of Dallas must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal**

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

**City of Dallas may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
City of Dallas must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may be entitled to a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

**City of Dallas may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

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 timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against City of Dallas or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against City of Dallas or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against City of Dallas or the Claims Administrator.

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

SECTION 10 - 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 any one of the following:

- another employer sponsored health benefits 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 auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

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 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** or call the toll-free number on your ID card 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:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

- 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 pays benefits first is the one that has been in effect the longest. 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 without specifying that one party 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;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; Only expenses normally paid by the Plan will be paid under COB; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

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 Participant 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.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the primary plan's allowable expense.
- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.

- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense When This Plan is Secondary

When this Plan is secondary, the allowable expense is the primary plan's Network rate. 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.

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

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

- employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary

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 are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Right to Receive and Release Needed Information

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

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

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 UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If City of Dallas pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to City of Dallas if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment City of Dallas made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

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

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

SECTION 11 - 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 you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent 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 provides an advancement of benefits to you or your Dependent during the time period of the Deductible and/or meeting the 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 it has advanced 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 you 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 considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a

Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

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

Right to Reimbursement

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

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity who caused the Sickness, Injury or damages;
- City of Dallas in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers' compensation coverage; or
  - any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
- the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- 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) or judgment, 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.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - complying with the terms of this section;
  - providing any relevant information requested;
  - signing and/or delivering documents at its request;
  - notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - responding 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 before releasing any party from liability or payment of medical expenses.
- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- you may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- 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 provided for a Sickness or Injury caused by a third party.
- the Plan's rights will not be reduced due to your own negligence.
- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including 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 apply to the parents, guardian, or other representative of a Dependent child 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.
- 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.

- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- if a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Subrogation – 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. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

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

When your coverage ends, City of Dallas 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 coverage ended, even if the underlying medical condition occurred before your coverage ended.

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

- the last day of the month your employment with the Company ends;
- the date the Plan ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you are no longer eligible;
- the last day of the month UnitedHealthcare receives written notice from City of Dallas to end your coverage, or the date requested in the notice, if later; or
- the last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

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

- the date your coverage ends;
- the last day of the month you stop making the required contributions;
- the last day of the month UnitedHealthcare receives written notice from City of Dallas to end your coverage, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

The Plan will provide written notice to you that your coverage has ended if any of the following occur:

- you permit an unauthorized person to use your ID card or you use another person's ID card;
- you knowingly give UnitedHealthcare false material information including, but not limited to, false information relating to another person's eligibility or status as a Dependent;

- you commit an act of physical or verbal abuse that imposes a threat to City of Dallas' staff, UnitedHealthcare's staff, a provider or another Covered Person; or
- you violate any terms of the Plan.

Note: City of Dallas has the right to demand that you pay back Benefits City of Dallas paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to City of Dallas proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon City of Dallas' request, that the child continues to meet these conditions.

The proof might include medical examinations at City of Dallas' expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under COBRA.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if City of Dallas is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

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

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

- a Participant;

- a Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines 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 considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
City of Dallas files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months 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 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.

[2]This is a qualifying event for any Retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Participant's death if the Participant dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. 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 Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

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

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction.*

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation 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 the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

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

Once you have notified the Plan Administrator, 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 City of Dallas Benefit Service Center 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 the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA.* The contents of the notice must be such that the Plan Administrator 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 Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

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

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- 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 Participant 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 Participant and the Participant'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, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

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

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

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant'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 the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

Survivorship Coverage

If the employee dies while covered under the Plan, the surviving spouse and any eligible dependents may continue coverage under the Plan until the end of the month following a period of 90 days subsequent to the employee's death. After the initial 90 days following the employee's date of death, coverage is then available to the surviving spouse and any eligible dependents through the COBRA provision, except for a surviving spouse of an active uniformed officer killed in the line of duty. A surviving spouse of an active uniformed officer may continue coverage on the existing plan at active rates. If a surviving spouse remarries, coverage under the Plan will terminate.

A surviving spouse who is covered under a retiree Plan may continue coverage as long as he/she is eligible for pension benefits. Any dependents acquired through the remarriage of a retired employee's surviving spouse will not be eligible for coverage under the Plan.

A surviving spouse and eligible dependents of a retired employee may remain in the Plan after the death of the retired employee:

- If the person was covered as a dependent spouse of the deceased retired employee at the time of the retired employee's death and is eligible to receive pension benefits;
- If carried as a dependent child, the person remains a dependent of the surviving spouse, but only if the spouse is receiving monthly survivor's benefits from one of the retirement funds.

Coverage for all surviving dependents ceases if coverage for the surviving spouse stops because of death, termination of monthly benefits, or any other reason.

A retired employee, or a surviving spouse or dependent who is eligible for Medicare participation by reason of age or disability or any other reason, must enroll and remain enrolled in Medicare Parts A and B in order to retain eligibility in the Plan.

The City will pay the Medicare Part A monthly premium on behalf of the retired employees and spouses of retired employees who are not otherwise qualified for Medicare. Retired employees are responsible for notifying the City, otherwise, they will be responsible for payment of the Medicare Part A premium. The retired employee and retired employee's spouse are responsible for payment of all Medicare Part B premiums.

If a retired employee is enrolled in this Plan on January 1, and elects to discontinue coverage in this Plan, the retired employee will not be eligible to enroll at a later date or in a subsequent plan

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and City of Dallas;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

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 medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

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 City of Dallas

In order to make choices about your health care coverage and treatment, City of Dallas believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- City of Dallas and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

City of Dallas and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. City of Dallas and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. City of Dallas and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between City of Dallas, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not City of Dallas' agents or employees, nor are they agents or employees of UnitedHealthcare. City of Dallas and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

City of Dallas and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, City of Dallas and UnitedHealthcare arranges for health care providers to participate in a Network and pay Benefits. 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. They are not City of Dallas' employees nor are they employees of UnitedHealthcare. City of Dallas and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. City of Dallas and UnitedHealthcare are not liable for any act or omission of any provider.

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

City of Dallas as the Plan Administrator is solely responsible for:

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

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;

- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

City of Dallas and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

City of Dallas and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

Information and Records

City of Dallas and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. City of Dallas and UnitedHealthcare may request additional information from you to decide your claim for Benefits. City of Dallas and UnitedHealthcare will keep this information confidential. City of Dallas and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

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

City of Dallas and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan,

for appropriate medical review or quality assessment, or as City of Dallas is required to do by law or regulation. During and after the term of the Plan, City of Dallas and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements City of Dallas 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, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, City of Dallas and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

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

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but City of Dallas recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

City of Dallas and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. City of Dallas and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD 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 SPD, but it does not describe the Benefits provided by the Plan.

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

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 Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount of Eligible Expenses you must pay for Covered Health Services in a calendar year before you are eligible to begin receiving Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights.*

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

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

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).

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

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

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as UnitedHealthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

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 patient is not allowed to choose which treatment will be received.

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.*

Company – City of Dallas.

Complications of Pregnancy – a condition suffered by a Dependent child that requires medical treatment before or after Pregnancy ends.

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

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects 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 to certain employees and their dependents whose group health insurance has been terminated.

Continuous Creditable Coverage – health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- a group health plan;
- health insurance coverage;
- Medicare;
- Medicaid;
- medical and dental care for members and certain former members of the uniformed services, and for their dependents;
- a medical care program of the Indian Health Services Program or a tribal organization;
- a state health benefits risk pool;
- The Federal Employees Health Benefits Program;
- The State Children's Health Insurance Program (S-CHIP);
- health plans established and maintained by foreign governments or political subdivisions and by the U.S. government;
- any public health benefit program provided by a state, county, or other political subdivision of a state; or
- a health benefit plan under the Peace Corps Act.

If you or your eligible Dependents were covered by any of the above plans before first becoming covered by this Plan, you should have received a Certificate of Creditable Coverage when that plan's coverage ended.

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 Claims Administrator. 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 function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which City of Dallas determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms;
- consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below;

- not provided for the convenience of the Covered Person, Physician, facility or any other person;
- included in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions.*

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community; and
- "prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

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, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient 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.

Deductible – see Annual Deductible.

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

Designated Facility – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specific conditions.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between a Participant and one other person of the same sex. Both persons must:

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent and have furnished documents to support at least two of the following conditions of such financial interdependence:
  - they have a single dedicated relationship of at least 6 months duration;
  - they have joint ownership of a residence; or
  - they have at least two of the following:
    - a joint ownership of an automobile;
    - a joint checking, bank or investment account;
    - a joint credit account;
    - a lease for a residence identifying both partners as tenants; or
    - a will and/or life insurance policies which designate the other as primary beneficiary.

The Participant and Domestic Partner must jointly sign an affidavit of domestic partnership provided by City of Dallas Benefit Service Center upon your request.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – charges for Covered Health Services that are provided while the Plan is in effect, determined as follows:

For:	Eligible Expenses are Based On:
Network Providers	contracted rates with that provider
Non-Network Providers	If you receive Covered Health Services from a non-Network provider in an Emergency, Eligible Expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or Substance Use Disorders 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.

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

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – City of Dallas.

EOB – see Explanation of Benefits (EOB).

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

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

Exceptions:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and City of Dallas may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UnitedHealthcare and City of Dallas must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

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

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, 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 or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

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

Inpatient Rehabilitation Facility – a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides physical therapy, occupational therapy and/or speech therapy on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

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

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by City of Dallas. The KRS program provides:

- specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

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

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

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

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

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the organization or individual designated by City of Dallas who provides or arranges Mental Health and Substance Use Disorder Services under the Plan. The current Administrator is UnitedHealthcare

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions.*

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by City of Dallas. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator'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 some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network provider. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Open Enrollment – the period of time, determined by City of Dallas, during which eligible Participants may enroll themselves and their Dependents under the Plan. City of Dallas determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

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

Participant – a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Personal Health Support – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

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 – 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.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that 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 City of Dallas Medical Plan.

Plan Administrator – City of Dallas or its designee.

Plan Sponsor – City of Dallas.

Preexisting Condition – any Sickness or Injury that is identified by the Plan Administrator as having been diagnosed or treated, or for which Prescription Drugs were prescribed or taken within the six months before coverage under this Plan begins (or the first day of any waiting period, if earlier). A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.

If you have Continuous Creditable Coverage, you or your Dependent will be eligible to receive Plan Benefits for a Preexisting Condition. Continuous Creditable Coverage is defined in this section.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with Pregnancy.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

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 surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

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

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the 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.

Retired Employee – an Employee who retires while covered under the Plan.

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

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights.*

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider.

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

Skilled Care – skilled nursing, teaching, and 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 patient;
- 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.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Specialist Physician.

Spouse – an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded.

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, 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 Covered Person with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members 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 doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program – a program that identifies network Physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the 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 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**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and City of Dallas may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and City of Dallas must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.
- UnitedHealthcare and City of Dallas may, in their discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that UnitedHealthcare and City of Dallas do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies must be available in published peer-reviewed medical literature that would allow UnitedHealthcare and City of Dallas to conclude that the service is promising but unproven.
  - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare and City of Dallas's discretion. Other apparently similar promising but unproven services may not qualify.

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 minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

UnitedHealthcare Services, Inc.

185 Asylum Street
Hartford, CT 06103-3408

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

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Services, Inc.. The named fiduciary of Plan is City of Dallas, the Plan Sponsor.

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

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

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

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

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

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

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 Summary Plan Description (see Section 5, *Plan Highlights*) 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 Dependents as defined in the Summary Plan Description in Section 14, *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 the number on the back of your ID card.

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 ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your 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 the toll-free phone number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description 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 people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

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 insurance plan for Covered Health Services described in the Summary Plan Description 5, *Plan Highlights*) 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 your health 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 receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *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 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps facilities and clinics online based on location, compare 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 even work with a single 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 via phone (toll-free) by calling 1-866-774-4626.

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 1-877-801-3507 (toll-free).

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