UnitedHealthcare
Choice Plus
Consumer Driven Health (CDH) Plan with
Health Savings Account (HSA)

For

City of Austin

Effective: January 1, 2015
Group Number: 704244

UnitedHealthcare®
A UnitedHealth Group Company

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UnitedHealthcare Choice Plus CDH Plan with HSA

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Section 1
Plan Provisions

This document constitutes the entire 2015 UnitedHealthcare Choice Plus CDH Plan with HSA (Plan) for City of Austin (City) eligible Employees, Dependents, or Surviving Family Members and, if applicable, Employees of an Affiliated Employer and their eligible Dependents. This Plan will refer to the primary insured (i.e., Employee or Surviving Family Member) as "Employee." The Plan does not constitute a contract of employment.

1.1 PURPOSE

The City has contracted with United HealthCare Services, Inc. (UnitedHealthcare), a private healthcare claims administrator, to administer this Plan and process the payment or reimbursement of specified expenses incurred by eligible Covered Persons. The purpose of this document is to set forth provisions of the Plan that provide and/or affect payment or reimbursement. The Plan is intended to comply with all applicable laws and shall be interpreted accordingly.

This plan document is hereby designated as the UnitedHealthcare Choice Plus CDH Plan with HSA for City Employees, and the provisions contained in this Plan will be the basis for the administration of the benefits program described in this document.

1.2 AMENDMENT TO OR TERMINATION OF THE PLAN

The Plan may be amended, canceled, or discontinued at any time by the City Manager without the consent of or prior notice to any Covered Person. In the event of an amendment or termination of the Plan, written notice will be provided to covered Employees. Such amendment or termination will become effective on the date set forth in such notice.

1.3 EFFECTIVE DATE OF PLAN

The Effective Date of the Plan, as amended in its entirety, is January 1, 2015. As of the Effective Date of the Plan, eligibility for and the amount of benefits, if any, payable with respect to Covered Persons, are determined pursuant to the terms and conditions of this Plan.

1.4 BENEFITS GUIDE

It is intended that each Employee eligible for coverage under this Plan shall be issued an Employee Benefits Guide (Guide), which includes a summary of Plan provisions. However, this document at all times governs and controls in the case of any conflict.

1.5 MISSTATEMENT ON APPLICATION

If any relevant fact has been misstated by or on behalf of any person to obtain coverage under the Plan, the true facts will be used to determine whether coverage is in force and the extent, if any, of such coverage. Upon the discovery of such misstatement, equitable adjustment of any contributions or benefits paid will be made and such persons shall lose coverage under the Plan subject to the Time Limit for Misstatement.

1.6 TIME LIMIT FOR MISSTATEMENT

The City will provide written notice to the Employee that coverage has ended on the date the City identifies fraud or misrepresentation, or because the Employee knowingly provided false material information. Examples include false information relating to eligibility or status as a Covered Person.

During the first two years of coverage under the Plan, the Plan Administrator has the right to demand that the Employee pay back all Benefits paid, or paid in the name of or on behalf of the Employee or Dependent, during the time such person was incorrectly covered under the Plan. After the first two years, the Plan Administrator can demand that the Employee pay back these Benefits only if the written application contained a fraudulent misstatement.

1.7 APPLICABLE LAW

Any provision of the Plan, which, as of the Effective Date, is in conflict with the law or regulation of any governmental body or agency that has jurisdiction over the Plan, will be interpreted to conform to the minimum requirements of such law.

1.8 ERROR/DELAY

Errors made on the records of the City and delays in making entries on such records will not invalidate coverage or cause coverage to be in force or to continue in force. Rather, the Effective Date of coverage will be determined solely in accordance with the provisions of the Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an adjustment will be made to reflect the correct amount of the contributions. The City has the right to collect contributions owed by the Employee. Conversely, the Employee will be reimbursed if an overpayment occurs. If an overpayment occurs due to an error the Employee makes when completing an application for coverage, the City will reimburse the Employee up to a maximum of one month of premiums.

1.9 WAIVER

The failure to strictly enforce any provision of the Plan will not be construed as a waiver of the provision. Rather, the right is reserved to strictly enforce each and every provision of the Plan at any time regardless of prior conduct and regardless of the similarity of the circumstances or the number of prior occurrences.

1.10 WRITTEN NOTICE

Any written notice required under the Plan will be deemed received if sent by regular mail, postage prepaid, to the last address on the records of the City.

1.11 EFFECT OF CHANGES

All changes to the Plan will become effective as of a date established by the City Manager, except that no reduction in Plan-paid benefits will be effective with respect to Covered Expenses incurred prior to the date the change was effective.

1.12 ENTIRE CONTRACT

The Plan and the applications of the Covered Persons, if any, constitute the entire contract of Coverage under the Plan between the City, the Plan Administrator, and the Covered Persons.

1.13 INTERPRETATION OF BENEFITS

The Plan Administrator has the sole and exclusive discretion to do all of the following:

1. Interpret Benefits under the Plan.
2. Interpret the other terms, conditions, limitations, and exclusions set out in the Plan Document.
3. Make factual determinations related to the Plan and its Benefits.
4. The Plan Administrator may, in certain circumstances, for purposes of overall cost savings or efficiency, in its sole discretion, offer Benefits for services that would otherwise not be Covered

Services. The fact that the Plan Administrator does this in any particular case shall not in any way be deemed to require the Plan Administrator to do so in similar cases.

1.14 ADA REQUIREMENTS

The City and UnitedHealthcare are committed to complying with the Americans with Disabilities Act (ADA). Reasonable accommodation, including equal access to communications, will be provided on request. For more information, call the City of Austin, Human Resources Department, at (512) 974-3284 or (512) 974-2445 (TTY line) or UnitedHealthcare at (800) 430-7316.

Section 2
Schedule of Benefits

The following chart summarizes the coverage available under the Plan. For details refer to Covered Services and Benefits (Section 4).

This section lists the coverage levels available under the Plan. Definitions of terms, and any limitations or exclusions are explained in other sections of this Plan. In the case of Out-of-Network benefits, the Covered Person may be responsible for paying charges in excess of the Maximum Allowable Charge in addition to any Deductible, or Coinsurance required by the Plan.

To receive In-Network benefits, care must be provided by a UnitedHealthcare Choice Plus In-Network Provider, a Routine Vision Network Provider, an In-Network Pharmacy, or an In-Network UnitedHealthcare specialty pharmacy.

Some services require that UnitedHealthcare's Care Coordination staff receive Pre-Notification before services are received. For In-Network services that require Pre-Notification, your Provider is responsible for notifying Care Coordination.

For Out-of-Network services that require Pre-Notification, you are responsible for notifying Care Coordination. Failure to provide Pre-Notification will result in a reduction in Plan-paid benefits to 50% of Maximum Allowable Charges for Out-of-Network services.

2.1 GENERAL PROVISIONS

Deductible: Employee Only Coverage

In-Network: $1,500 per Covered Person, per Calendar Year.

Out-of-Network: $3,000 per Covered Person, per Calendar Year.

Deductible: Employee and Dependent Coverage

In-Network: $3,000 per Calendar Year.

Out-of-Network: $6,000 per Calendar Year.

Out-of-Pocket Maximum (Per Calendar Year)

In-Network: Employee Only: $5,000, Employee and Dependent: $10,000.

Out-of-Network: Employee Only: $10,000, Employee and Dependent: $20,000.

Lifetime Maximum Benefit

Unlimited.

Out-of-Network Benefits

Plan pays 60% up to Maximum Allowable Charge. Out-of-Network benefits are subject to In-Network benefit plan limits and Pre-approval and Pre-Notification requirements.

2.2 MEDICAL BENEFITS

Doctor's Charges

Office

In-Network: Primary Care Physician: Plan pays 80% after Deductible. Specialist: Plan pays 80% after Deductible.

Preventive Care

In-Network: Plan pays 100%, no Deductible.

Urgent Care Center

In-Network: Plan pays 80% after Deductible.

Maternity

In-Network: Plan pays 80% after Deductible.

Allergy Injections

In-Network: Plan pays 80% after Deductible.

Immunizations

In-Network: Plan pays 100%, no Deductible.

Shingles vaccinations are covered at 100%, no Deductible, regardless of age.

Outpatient Physical and Occupational Therapy

In-Network: Plan pays 80% after Deductible.

Chiropractic

Limited to 20 visits per Covered Person, per Calendar Year.

In-Network: Plan pays 80% after Deductible.

Speech Therapy

Must be prescribed by a Doctor.

In-Network: Plan pays 80% after Deductible.

Acupuncture

Limited to 12 visits per Covered Person, per Calendar Year.

In-Network: Plan pays 80% after Deductible.

Therapeutic Services

Includes chemotherapy, infusion therapy and dialysis.

In-Network: Plan pays 80% after Deductible.

Outpatient Diagnostic X-Ray and Laboratory

In-Network: Plan pays 80% after Deductible for the following services:

CT Scans, MRIs, PET Scans, all other laboratory, x-ray services, and nuclear medicine.

Pre-Notification is required for all radiology procedures.

Outpatient Surgical Facility

Doctor and Anesthesiologist services, Plan pays 80% after Deductible.

Colonoscopies and related anesthesia are covered at 100%, no Deductible, regardless of age.

Female Sterilization is covered at 100%, no Deductible.

Hospital Services

Inpatient Care: Including laboratory and radiology services. Limited to Semi-Private Room rate. Care Coordination must receive Pre-Notification for Inpatient Admission. Failure to provide Pre-Notification will result in a reduction in Plan-paid benefits to 50% for Out-of-Network Hospital admissions.

In-Network: Plan pays 80% after Deductible.

Outpatient Care: Therapeutic Services including chemotherapy, infusion therapy, and dialysis.

In-Network: Plan pays 80% after Deductible.

Hospital Emergency Room Services:

Plan pays 80% after Deductible.

Mental Health Care

Outpatient Care:

In-Network: Plan pays 80% after Deductible.

Partial Hospitalization:

In-Network: Plan pays 80% after Deductible.

Inpatient Care: Limited to Semi-Private Room rate. OptumHealth Behavioral Solutions must receive Pre-Notification for Inpatient Admissions. Failure to provide Pre-Notification will result in a reduction in Plan-paid benefits to 50% for Out-of-Network Hospital admissions.

In-Network: Plan pays 80% after Deductible.

Chemical Dependency

Limited to Semi-Private Room rate. Care Coordination must receive Pre-Notification for Inpatient Admission. Failure to provide Pre-Notification will result in a reduction in Plan-paid benefits to 50% for Out-of-Network Hospital admissions.

In-Network: Plan pays 80% after Deductible.

Ambulance Service

Plan pays 80% after Deductible.

Extended Care/Skilled Nursing Facility

Limited to 60 days per Covered Person, per Calendar Year. Limited to Semi-Private Room rate. Care Coordination must receive Pre-Notification for Inpatient Admission. Failure to provide Pre-

Notification will result in a reduction in Plan-paid benefits to 50% for Out-of-Network facility admissions.

In-Network: Plan pays 80% after Deductible.

Home Health Care

Limited to 120 visits per Covered Person, per Calendar Year. Care Coordination must receive Pre-Notification. Failure to provide Pre-Notification will result in a reduction in Plan-paid benefits to 50% for Out-of-Network services.

In-Network: Plan pays 80% after Deductible.

Hospice Care

Care Coordination must receive Pre-Notification. Failure to provide Pre-Notification will result in a reduction in Plan-paid benefits to 50% for Out-of-Network services.

In-Network: Plan pays 80% after Deductible.

Durable Medical Equipment and Medical Supplies

Care Coordination must receive Pre-Notification for items over $1,000. Failure to provide Pre-Notification will result in a reduction in Plan-paid benefits to 50% for equipment purchased from Out-of-Network Providers.

In-Network: Plan pays 80% after Deductible.

Diabetic Care

Diabetic and pre-Diabetic Counseling, Plan pays 80% after Deductible.

Diabetic Equipment, Plan pays 80% after Deductible. Care Coordination must receive Pre-Notification for items over $1,000.

Diabetic Supplies Insulin pumps and supplies are covered at 80% after Deductible. Care Coordination must receive Pre-Notification. See also Prescription Drug Benefits.

Prosthetic Appliances and Orthotic Devices

Plan pays 80% after Deductible. Must receive Pre-Notification for items over $1,000. (Non-custom or off-the-shelf orthotics received in the Physician office are paid at 80% after Deductible.)

Foreign-International Services

Plan pays 80% after deductible. No coverage for services to treat a condition that does not meet the definition of Emergency Care.

Other Covered Medical Expenses

In-Network: Plan pays 80% after Deductible.

See Section 4 for Covered Services and Benefits.

Routine Vision Care

Limited to one routine eye examination per Covered Person, per Calendar Year.

In-Network: Plan pays 80% after deductible.

2.3 PRESCRIPTION DRUG BENEFITS

Health Care Reform mandated preventive medications: Plan pays 100%, no Deductible.

Medications on the expanded preventive Prescription Drug List: Plan pays 80%, no Deductible

All other covered medications: Plan pays 80% after deductible.

Retail Pharmacy

In-Network: Limited to a 90-day supply per prescription.

Out-of-Network: No coverage.

Mail Order Pharmacy

In-Network: Up to a 90-day supply per prescription.

Out-of-Network: No coverage.

Compound Drugs

Compound drugs are defined and explained in sections 6.1 and 6.2.

Mandatory Specialty Pharmacy Program

Benefits are provided for specialty prescription drug products. If you require a specialty prescription drug, you will be directed to a designated pharmacy with whom UnitedHealthcare has arrangements to provide those specialty prescription drug products. When you are directed to a designated pharmacy and you choose not to obtain your specialty prescription drug from the designated pharmacy, there will be no coverage.

Specialty prescription drugs are generally high cost, self-injectable biotechnology drugs used to treat patients with certain Illnesses. You may access a complete list of specialty prescription drugs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Smoking Cessation Program Drugs

After completion of the City of Austin's smoking cessation program conducted by the City's Employee Assistance Program, a Covered Person who obtains a prescription for an FDA approved smoking cessation drug or an over-the-counter nicotine replacement therapy drug (patch, gum, etc.) from his or her Physician may purchase the drug from either a retail pharmacy or through mail order with no Deductible or Coinsurance for six months.

Section 3
How the Plan Works

3.1 PROVIDER INFORMATION

You are entitled to medical care and services from In-Network Providers including Medically Appropriate medical, surgical, diagnostic, therapeutic, and preventive services that are generally and customarily provided in the Service Area. Some services may not be covered. To be covered, a service that is Medically Appropriate must also be described in Covered Services and Benefits. Even though a Physician or other Health Care Professional has performed, prescribed, or recommended a service does not mean it is Medically Appropriate or that it is covered under Covered Services and Benefits. Some Covered Services may also require Pre-Notification to UnitedHealthcare.

3.2 CONTINUITY OF CARE

If you are under the care of an In-Network Provider who stops participating in UnitedHealthcare's network, UnitedHealthcare will continue coverage for that Provider's Covered Services if all the following conditions are met:

1. You have a disability, acute condition, life threatening illness, or are past the 24th week of pregnancy.
2. The Provider submits a written request to UnitedHealthcare to continue coverage of your care that identifies the condition for which you are being treated and indicates that the Provider reasonably believes that discontinuing Treatment could cause you harm.
3. The Provider agrees to continue accepting the same reimbursement that applied when participating in UnitedHealthcare's network, and not to seek payment from you for any amounts for which you would not be responsible if the Provider were still participating in UnitedHealthcare's network.

Continuity coverage shall not extend for more than 90 days (or more than nine months if you have been diagnosed with a terminal Illness) beyond the date the Provider's termination takes effect. If you are past the 24th week of pregnancy when the Provider's termination takes effect, coverage may be extended through delivery, immediate postpartum care, and the follow-up check-up within the first six weeks of delivery.

3.3 AVAILABILITY OF PROVIDERS

UnitedHealthcare cannot guarantee the availability or continued participation of a particular Provider. Either UnitedHealthcare or any In-Network Provider may terminate the Provider contract or limit the number of Members that will be accepted as patients.

3.4 IN-NETWORK AND OUT-OF-NETWORK BENEFITS

The level of benefits for Covered Persons depends on whether services are provided by an In-Network or Out-of-Network Provider, and according to the Schedule of Benefits.

When In-Network Providers are not available to perform certain services, Covered Services received from Out-of-Network Providers are payable at the In-Network level. Services must be pre-approved by the Plan Administrator to be covered at the In-Network level. Services not pre-approved will be payable at the Out-of-Network level.

When you receive Covered Services from In-Network Providers, you are not responsible for any difference between the eligible expenses and the amount the Provider bills. When you receive Covered Services from Out-of-Network Providers, you may be responsible for paying any difference between the amount the Provider bills you and the amount the Plan pays for eligible expenses.

3.5 NON-RESIDENT BENEFITS

Covered Persons who are determined by the City and UnitedHealthcare to live outside a UnitedHealthcare Service Area are called Non-Residents. Covered Services for Non-Residents will be reimbursed at the In-Network benefit level.

3.6 IN-NETWORK PROVIDER NOT AVAILABLE

If it is determined that an In-Network Provider is not available to meet the needs of a Covered Person, the services of an Out-of-Network Provider will be reimbursed at the In-Network level.

You may obtain Covered Services from Providers who are not part of UnitedHealthcare's network of In-Network Providers when receiving Emergency Care. Also, court-ordered Dependents living outside the Service Area may use Out-of-Network Providers.

If Covered Services are not available from In-Network Providers within the UnitedHealthcare Service Area, UnitedHealthcare will allow you to use an Out-of-Network Provider, if approved by UnitedHealthcare. To receive services from an Out-of-Network Provider the following procedures will apply:

1. Reasonably requested documentation must be received by UnitedHealthcare.
2. The approval will be provided within an appropriate time, not to exceed five business days, based on the circumstances and your condition.
3. When UnitedHealthcare approves services by an Out-of-Network Provider, UnitedHealthcare will reimburse the Out-of-Network Provider at the Allowable Amount or otherwise agreed rate, less the applicable Deductible and Coinsurance. You are responsible only for the Coinsurance or Deductibles for such Covered Services.

3.7 INDIVIDUAL DEDUCTIBLE

The Deductible listed on the Schedule of Benefits must be met each Calendar Year, before Coinsurance benefits are payable under the Plan. Only eligible expenses may be used to meet the Deductible. The Plan Administrator may allocate the Deductible to any Covered Expenses and to apportion the benefits to the Covered Person and any assignees.

In the event a Covered Person is confined for an Inpatient Admission on December 31, expenses for that Inpatient Admission are not subject to the Deductible for the following year.

Covered Expenses applied toward the In-Network Deductible will not apply toward the Out-of-Network Deductible. Covered Expenses applied toward the Out-of-Network Deductible will apply toward the In-Network Deductible.

Amounts paid toward the Deductible for Covered Expenses 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 Deductible.

3.8 FAMILY DEDUCTIBLE

Once the Family Deductible has been met, claims already submitted by additional family members may be eligible for payment. If you contact the Plan Administrator, adjustments can be made on Deductibles applied to such expenses.

3.9 ANNUAL OUT-OF-POCKET MAXIMUM

The maximum amount a Covered Person is required to pay in Out-of-Pocket Covered Expenses in any Calendar Year is dependent on whether the Out-of-Pocket Covered Expense is a result of charges incurred In-Network or Out-of-Network.

Covered Expenses applied toward the In-Network Out-of-Pocket Maximum will not apply toward the Out-of-Network Out-of-Pocket Maximum. Covered Expenses applied toward the Out-of-Network Out-of-Pocket Maximum will apply toward the In-Network Out-of-Pocket Maximum.

1. In-Network:

   After a Covered Person with Employee only coverage incurs $5,000, or after a Covered Person with Employee and Dependent coverage incurs $10,000 in Out-of-Pocket Covered Expenses in any Calendar Year resulting from charges incurred In-Network or Out-of-

Network, benefits for all other In-Network Covered Expenses incurred during the Calendar Year will be payable at 100% for the remainder of that Calendar Year.

a. Out-of-Pocket Covered Expenses include:

   1) The Covered Person's Deductible incurred In-Network or Out-of-Network.

   2) Coinsurance paid by the Covered Person for Covered Expenses incurred In-Network or Out-of-Network.

   3) Coinsurance paid for Medical Benefits or Prescription Drug Benefits.

2. Out-of-Network:

   After a Covered Person with Employee only coverage incurs $10,000 or after a Covered Person with Employee and Dependent coverage incurs $20,000 in Out-of-Pocket Covered Expenses in any Calendar Year resulting from charges incurred Out-of-Network, benefits for all other Covered Expenses incurred during the Calendar Year will be payable at 100% for the remainder of that Calendar Year.

   a. Out-of-Pocket Covered Expenses include:

      1) The Covered Person's Out-of-Network $3,000 annual Deductible for Employee only coverage, or $6,000 annual Deductible for Employee and Dependent coverage.

      2) Coinsurance paid by the Covered Person for Covered Expenses incurred Out-of-Network.

      3) Coinsurance paid for Medical Benefits and Prescription Drug Benefits.

      4) Any fee beyond the Maximum Allowable Charge for a particular service or supply.

   b. Out-of-Pocket Covered Expenses do not include:

      1) Penalties resulting from non-compliance with Pre-Notification and Care Coordination Programs.

3.10 LIFETIME MAXIMUM BENEFIT

Unlimited.

3.11 PROVIDER COMMUNICATION

UnitedHealthcare will not prohibit, attempt to prohibit or discourage any Provider from discussing or communicating to you or your designee any information or opinions regarding your health care, any provisions of the Plan as it relates to your medical needs, or the fact that the Provider's contract with UnitedHealthcare has terminated or that the Provider will no longer be providing services under UnitedHealthcare.

3.12 REFUSAL TO ACCEPT TREATMENT

You may, for personal reasons, refuse to accept procedures or Treatment by an In-Network Provider. In-Network Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Provider-patient relationship and as obstructing the provision of proper medical care. In-Network Providers shall use their best efforts to render all necessary and appropriate Professional Services in a manner compatible with your wishes, insofar as this can be done consistent with the In-Network Provider's judgment as to the requirements of proper medical practice. If you refuse to follow a recommended Treatment or procedure, and the In-Network Provider informed you of his or her belief that no professionally acceptable alternative exists, neither UnitedHealthcare nor any In-Network Provider shall have any further responsibility to provide care for the condition under Treatment.

3.13 MEMBER COMPLAINT PROCEDURE

Any problem or claim between you and UnitedHealthcare or between you and an In-Network Provider must be dealt with using the process described in Complaint and Appeal Procedures (Section 11). Complaints may concern non-medical or medical aspects of care as well as this Plan Document including its breach or termination.

3.14 IDENTIFICATION CARD

Cards issued by UnitedHealthcare under this Plan Document are for identification only. Any person receiving services or benefits to which he or she is not entitled to under the provisions of this Plan Document will be liable for the actual cost of such services or benefits.

3.15 MEMBER CLAIMS REFUND

You are not expected to make payments, other than required Deductibles and Coinsurance, for any benefits provided hereunder. However, if you make such payments, you may send UnitedHealthcare a claim for reimbursement, and when a refund is in order, the Provider shall make such refund to you. Please access special reimbursement claim forms posted on the City's internet website, austintexas.gov/benefits, for medical services and for contact examinations and fittings. Your claim will be allowed only if you notify UnitedHealthcare within 90 days from the date on which Covered Expenses were first incurred, unless it can be shown that it was not reasonably possible to give notice within the time limit, and that notice was given as soon as reasonably possible. However, benefits will not be allowed if notice of claim is made beyond one year from the date Covered Expenses were incurred. Prescription Drug claims which must be filed within 90 days of the date of purchase to qualify for reimbursement under the Prescription Drug Program. You must provide written proof of such payment to UnitedHealthcare within one year of occurrence. Within 15 days of receipt of written notice of an Out-of-Area or emergency claim, UnitedHealthcare shall acknowledge receipt of claim and begin any necessary investigation. It may be necessary for UnitedHealthcare to request additional information from you. Claims shall be acted upon within 15 business days of receipt of a completed claim unless you are notified that additional time is needed and why. UnitedHealthcare will act on a completed claim no later than 45 days after the additional time notification is given to you. You can also obtain a claim form by visiting **myuhc.com**, or calling the toll-free number on your ID card. 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:

1. your name and address;
2. the patient's name, age and relationship to the Employee;
3. the number as shown on your ID card;
4. the name, address and tax identification number of the Provider of the service(s);
5. a diagnosis from the Physician;
6. the date of service;
7. an itemized bill from the Provider that includes:
    a. the Current Procedural Terminology (CPT) codes;
    b. a description of, and the charge for, each service;
    c. the date the Sickness or Injury began; and

d. 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 or listed below.

UnitedHealthcare-(Medical Claims)
P.O. Box 30555
Salt Lake City, UT 84130-0555
(800) 430-7316

When filing a claim for Prescription Drug Benefits, your claims should be submitted to:

OptumRX
P.O. Box 29044
Hot Springs, AR 71903
(800) 430-7316

3.16 CLAIM OR BENEFIT RECONSIDERATION

If a claim or a request for benefits is partly or completely denied by UnitedHealthcare, you will receive a written explanation of the reason for the denial and be entitled to a full review. If you wish to request a review or have questions regarding the explanation of benefits, call or write customer service at the phone number or address on the back of your Identification Card. If you are not satisfied with the information received either on the call or in written correspondence, you may request an appeal of the decision or file a Complaint. You may obtain a review of the denial by following the process set out in Complaint and Appeal Procedures (Section 11).

3.17 LIMITATION OF LIABILITY

All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that service, or Benefits will not be paid, as determined by the Plan Administrator. 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.

3.18 PAYMENT OF BENEFITS

Medical Benefits are payable to the Employee whose Illness or Injury or whose Dependent's Illness or Injury is the basis of claim under this Plan, except as provided below.

3.19 INCAPACITY

If, in the opinion of the Plan Administrator, a valid release cannot be obtained for payment of any benefit payable under this Plan, the Plan Administrator may, at its option, make such payment to the individual or individuals as have, in the Plan Administrator's opinion, assumed the care and principal support of the Covered Person and are, therefore, equitably entitled thereto. In the event of the death of a Covered Person prior to such time as all benefit payments due that Covered Person have been made, the Plan Administrator may at its sole discretion and option, honor assignments, if any, made prior to the death of the Covered Person.

3.20 DISCHARGE

Any payment made by the Plan in accordance with provisions in this Section, will fully discharge the obligations of the Plan to the extent of such payment.

3.21 CLAIMS RECOVERY

If, for any reason, the Plan Administrator makes any payment in error, due to a mistake in fact, or in excess of the maximum amount necessary to satisfy the intent of the Plan's provision, the Plan Administrator will have the right to recover any excess payments from any other company, organization, or individual to whom, for whom, or with respect to whom, these payments have been made. This includes the right to recover excess payments from the Employee when payment has been made to the Employee. Benefits paid because a Covered Person or a Covered Person's Dependent misrepresented facts are also subject to recovery. If the Plan provides a Benefit for a Covered Person or a Covered Person's 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. The Plan has the right to recover Benefits it has advanced by: submitting a reminder letter to the Covered Person or Covered Person's Dependent that details any outstanding balance owed to the Plan; and conducting courtesy calls to the Covered Person or Covered Person's Dependent to discuss any outstanding balance owed to the Plan.

3.22 EFFECTIVE REPRESENTATIONS

All statements made by the City, the Plan Administrator or by a Covered Person will, in the absence of fraud, be considered representations and not warranties, and no statement made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by this document unless contained in a written application for benefits.

3.23 PLAN TERMINATION

The City Manager may terminate the Plan at any time. On termination, the rights of Covered Persons are limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to Employees in writing as soon as administratively feasible.

3.24 BENEFITS NOT SUBJECT TO ALIENATION

Except for claims from Out-of-Network Providers, no benefit payment under this Plan will be subject in any way to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same will be void. If the Plan Administrator finds that such an attempt has been made with respect to any payment due, or to become due, to any Employee, the Plan Administrator may, in its sole discretion, terminate the interest of such Employee or in such payment to or for the benefit of such Employee, as the Plan Administrator determines, and any such application will be a complete discharge of all liability with respect to such benefit payment.

Section 4
Covered Services and Benefits

Covered Expenses include the services and supplies described below and are Medically Appropriate for the Treatment of an Illness or Injury covered under the Plan, and do not exceed the Maximum Allowable Charge. Benefits for Covered Expenses are subject to applicable Deductible, Coinsurance, limitation, or Pre-Notification requirements.

Covered Services - those health services, including services, or supplies which the Plan Administrator determines to be:

1. provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms;

2. consistent with nationally recognized Scientific Evidence as available, and Prevailing Medical Standards and Clinical Guidelines as described below;

UnitedHealthcare 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 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.

Some services require that UnitedHealthcare's Care Coordination receive Pre-Notification before the services are received. For In-Network services, your Provider is responsible for notifying Care Coordination.

You are responsible for notifying Care Coordination for Out-of-Network services. Failure to provide Pre-Notification will result in a reduction in Plan-paid benefits to 50% of the Maximum Allowable Charges for all related Covered Services. The additional Coinsurance will not apply toward the Out-of-Pocket Maximum.

4.1 PROFESSIONAL SERVICES

Certain services may be restricted in Limitations and Exclusions (Section 5).

PCP or Specialist Office Visits. Services provided in the medical office of the PCP or Specialist for the diagnosis and Treatment of Illness or Injury.

PCP or Specialist Home Visits. Medically Appropriate home visits provided by Physicians.

Services of Physicians for diagnosis, Treatment, and consultation are provided while you are an inpatient or outpatient in a facility for authorized Medically Appropriate Covered Services or Emergency Care as defined herein.

4.2 DOCTOR'S CHARGES

1. Office - Prosessional Services performed in a Doctor's office for Treatment of Illness or Injury. Covered Expenses include charges for:
    a. Examinations.
    b. Treatments.
    c. Surgical Procedures.
    d. Second Surgical Opinion.
    e. Interpretation of clinical and pathological laboratory services.
    f. Interpretation of X-rays, electrocardiograms (EKGs), electroencephalograms (EEGs), and mammograms.
    g. Diagnosis of Illness, limited to initial diagnosis of the cause of Illness and Treatment of underlying medical conditions.
    h. Allergy testing.
    i. Injections.
    j. Food and Drug Administration-approved contraceptive devices requiring a prescription, including diaphragms, contraceptive management implant devices, depo provera injections, and intrauterine contraceptive devices (IUDs).
    k. Nutritional counseling by a dietitian.

l. Dental Expenses limited to:

1) Treatment of fractures and traumatic dislocations of the jawbone.

2) Cutting procedures in the oral cavity for tumors or cysts of the jawbone.

3) Treatment necessitated by Injury to sound natural teeth. Sound is defined as undiseased, undamaged, natural teeth, or natural teeth restored to function. Treatment must be received or Care Coordination must have received Pre-Notification within six months from the date of Injury.

4) Cutting to realign the jawbone (osteotomies or arthroplasties).

5) Surgical Procedures for temporomandibular joint (TMJ) dysfunction require Pre-Notification. Failure to provide Pre-Notification for TMJ surgery will result in a reduction in the level of Plan-paid benefits to 50% of the Maximum Allowable Charges for all related Covered Services. The additional Coinsurance will not apply toward the Out-of-Pocket Maximum. Physical Therapy following TMJ surgery is a Covered Expense.

6) Covered dental services received from Out-of-Network Providers will be reimbursed at the In-Network level when approved by the Plan Administrator.

m. The Plan pays for one preventive examination per Calendar Year for adults at 100%, no Deductible. In addition to the preventive examination, the Plan will pay for one well-woman exam per Calendar Year at 100%, no Deductible. For infants and children, the Plan provides coverage based on age appropriate guidelines recommended by the U.S. Preventive Taskforce. Preventive or routine means services are performed in the absence of any sign or symptoms of Illness or Injury.

n. State-required immunizations and inoculations for children. Adult immunizations and inoculations.

o. Heptavalent pneumococcal conjugate vaccine (Prevnar) for children through age six.

2. Urgent Care Center

a. Treatment at an Urgent Care Center.

b. Minor emergency centers located in a Hospital are payable as a Hospital Emergency Room.

3. Inpatient and outpatient services provided in a Hospital or Outpatient Surgical Facility.

4. Maternity Services of a Doctor or Midwife for maternity care, including prenatal care, post-natal care, and delivery.

5. Allergy and other Covered Injections as listed on the Schedule of Benefits, Section 2.

6. Outpatient Physical and Occupational Therapy provided by a licensed physical or occupational therapist, when Doctor-prescribed.

7. Services of a Chiropractor for spinal manipulative care and musculoskeletal care limited to 20 visits per Covered Person, per Calendar Year. Benefits for Chiropractic care when provided by a Chiropractor in the Provider's office. Benefits include diagnosis and related services and are limited to one visit and Treatment per day.

8. Speech Therapy.

9. Acupuncture limited to 12 visits per Covered Person, per Calendar Year. Acupuncture services for pain therapy when the service is performed by a Provider in the Provider's office.
10. Therapeutic Services.
11. The Plan provides Benefits for vision therapy when rendered in connection with the following visual disorders: amblyopia (lazy eye), accommodative disorders, ocular motor and visual motor dysfunctions, and binocular vision disorders (e.g. strabismus).

4.3 INPATIENT HOSPITAL SERVICES

Covered Services include:

1. Semi-Private Room and board, with no limit to number of days unless otherwise indicated.
2. Private rooms when Medically Appropriate and authorized by UnitedHealthcare.
3. Special diets and meals when Medically Appropriate and authorized by UnitedHealthcare.
4. Use of intensive care or cardiac care units and related services when Medically Appropriate.
5. Use of operating and delivery rooms and related facilities.
6. Anesthesia and oxygen services.
7. Laboratory, x-ray, and other diagnostic services.
8. Drugs, medications, biologicals, and their administration.
9. Special duty and private duty nursing when Medically Appropriate and authorized by UnitedHealthcare.
10. Radiation therapy, inhalation therapy, and chemotherapy.
11. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for you.
12. Human organ or tissue transplants.

Benefits are available for the transplant when the transplant meets the definition of a Covered Service, and is not an Experimental/Investigational or an Unproven Service. If the Covered Person is the recipient of an organ or tissue transplant, Covered Expenses include the evaluation, removal, and transportation of the donated organs and tissues. Care Coordination must Pre-approve all transplant services.

If the Covered Person is an organ or tissue donor, benefits are provided under the Plan only if benefits for the donation are not provided under any health coverage or health insurance available to the transplant recipient.

In the event that both the recipient and the donor are Covered Persons under the Plan, benefits will be determined separately for each.

Benefits are provided under the Plan only when a Provider customarily charges a transplant recipient for such care and services.

For In-Network Benefits, transplantation services must be received at a Designated Facility. UnitedHealthcare must be notified as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If UnitedHealthcare is not notified and if the transplantation services are not performed at a Designated Facility, all claims related to the transplantation will be reimbursed at the Out-of-Network level.

If the transplant procedure is performed at a Designated Facility, Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging, for the transplant recipient and a companion are available under this Plan as follows:

1. Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up.
2. Reasonable and necessary expenses for lodging for the patient, (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
3. Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Facility.
4. If the patient is a covered Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the $100 per diem rate.

There is a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.

4.4 OUTPATIENT FACILITY SERVICES

Pre-Notification may be required for the following services: outpatient surgery, radiation therapy and chemotherapy, infusion therapy, and dialysis.

4.5 OUTPATIENT LABORATORY AND X-RAY SERVICES

Laboratory and radiographic procedures, services, and materials, including diagnostic x-rays, x-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, laboratory tests, nuclear medicine, and therapeutic radiology services. Pre-Notification may be required.

4.6 REHABILITATION SERVICES

Rehabilitation services and physical, speech, and occupational therapies that in the opinion of a Physician are Medically Appropriate and meet or exceed your Treatment goals are provided when pre-notified. For a physically disabled person, Treatment goals may include maintenance of functioning or prevention or slowing of further deterioration. Rehabilitation Services may be provided in the Provider's office, in a Hospital as an inpatient, in an outpatient facility, or as home health care visits.

Treatment of Acquired Brain Injury will be covered the same as any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neuro-cognitive therapy and rehabilitation, neurobehavioral, neuro-physiological, neuropsychological and psycho-physiological testing or Treatment, neuro-feedback therapy, remediation, post-acute transition services, and community reintegration services are covered as a result of and related to an Acquired Brain Injury. To ensure that appropriate post-acute care Treatment is provided, UnitedHealthcare includes coverage for periodic reevaluation for a Member who: (1) has incurred an Acquired Brain Injury, (2) has been unresponsive to Treatment, and (3) becomes responsive to Treatment at a later date. Services may be provided at a Hospital, an acute or post-acute rehabilitation Hospital, an assisted living facility, or any other facility at which appropriate services or therapies may be provided.

4.7 MATERNITY CARE

Covered Services, which may require Pre-Notification, include:

1. Prenatal visits.
2. Use of Hospital delivery rooms and related facilities. A separate Deductible is not required for a newborn child at time of delivery if the newborn child is discharged with the mother. UnitedHealthcare provides coverage for Inpatient Care for the mother and the newborn in a Hospital for a minimum of 48 hours following an uncomplicated vaginal delivery, or 96 hours following an uncomplicated delivery by cesarean section.
3. Use of newborn nursery and related facilities.
4. Postnatal visits. If the mother or newborn is discharged before the minimum hours of inpatient coverage have passed, UnitedHealthcare provides coverage for Post-Delivery Care for the mother and newborn. Post-Delivery Care may be provided at the mother's home or an In-Network Provider's office or facility. A newborn child will not be required to receive health care services only from In-Network Providers if born outside the Service Area due to an emergency. UnitedHealthcare may require the newborn to be transferred to an In-Network facility, at UnitedHealthcare's expense, when determined to be Medically Appropriate by the newborn's treating Physician.

4.8 FAMILY PLANNING SERVICES

Covered Services, which may require Pre-Notification, include:

1. Diagnostic counseling, consultations, and planning services for family planning.
2. Insertion or removal of an intrauterine device (IUD), including the cost of the device.
3. Diaphragm or cervical cap fitting, including the cost of the device.
4. Insertion or removal of birth control device implanted under the skin, including the cost of the device.
5. Injectable contraceptive drugs, including the cost of the drug.
6. Voluntary sterilizations, including vasectomy and tubal ligation.

4.9 INFERTILITY SERVICES

Covered Services, which may require Pre-Notification, limited to the initial diagnosis of the cause of Illness and Treatment of underlying medical conditions.

4.10 PREGNANCY TERMINATIONS

Pregnancy terminations (abortions) must be provided by a licensed Physician, but UnitedHealthcare may allow other health Providers to provide Covered Services that may be provided under applicable state law by such Providers, including cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

4.11 MENTAL HEALTH CARE SERVICES

Outpatient Mental Health Care Covered Services include diagnostic evaluation and Treatment or crisis intervention.

Inpatient Mental Health Care Covered Services include inpatient Mental Health Care when authorized by UnitedHealthcare or its designated behavioral health administrator. Covered Services must be rendered based on an individual Treatment plan with specific attainable goals and objectives appropriate to both the patient and the Treatment modality of the program.

4.12 CHEMICAL DEPENDENCY SERVICES

Treatment of Chemical Dependency is the same as Treatment of any other physical Illness, but is restricted as described in Limitations and Exclusions. Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center. Some services may require Pre-Notification by UnitedHealthcare or its designated behavioral health administrator. A series of Treatments is a planned, structured, and organized program to promote chemical-free status which may include different facilities or modalities and is complete when Member is discharged on medical advice from inpatient detoxification, Inpatient Rehabilitation Facility /Treatment, partial hospitalization or intensive outpatient Treatment, or a series of these levels of Treatments without a lapse in Treatment or when Member fails to materially comply with the Treatment program for a period of 30 days.

4.13 EMERGENCY SERVICES

UnitedHealthcare will pay for a medical screening examination or other evaluation required by Texas or federal law and provided in the emergency department of a Hospital or comparable facility that is necessary to determine whether an emergency medical condition exists.

If post stabilization care is required after an Emergency Care condition has been treated and stabilized, the treating Physician or Provider will contact UnitedHealthcare or its designee, who must approve or deny coverage of the post stabilization care requested within one hour of receiving the call.

4.14 URGENT CARE

You may receive Emergency Care services in an urgent care center.

4.15 AMBULANCE SERVICES

Professional local ground ambulance service or air ambulance service to the nearest Hospital is covered when for Emergency Care, as defined in this Plan Document or between facilities when not done for the convenience of the family. Payment from Out-of-Network ambulance Providers will be based on billed charges for approved services.

4.16 EXTENDED CARE SERVICES

Benefits are available only for the care and Treatment of an Illness or Injury that would have otherwise required an inpatient stay at a Hospital. Pre-Notification is required.

Covered Services include the following when authorized by UnitedHealthcare:

1. Skilled Nursing Facility Services must be temporary and lead to rehabilitation and an increased ability to function. Custodial Care is not covered. If you remain in a Skilled Nursing Facility after your Physician discharges you or after you reach the maximum benefit period or period authorized by UnitedHealthcare, you will be liable for all subsequent costs incurred.
2. Hospice Care, that is provided by a Hospital, Skilled Nursing Facility, Hospice, or a duly licensed Hospice Care agency, is approved by UnitedHealthcare, and is focused on a palliative rather than curative Treatment for Members who have a medical condition and a prognosis of less than six months to live.
3. Home Health Care in the home by Health Care Professionals who are In-Network Providers, including but not limited to registered Nurses, licensed practical nurses, physical therapists, inhalation therapists, speech or hearing therapists, or home health aides. Benefits for Home Health Care are limited to 120 visits per Covered Person per Calendar Year, and no more than two visits per day. Each visit by a Nurse or physical, occupational, or speech therapist is considered one visit. Each visit of up to four hours is considered one visit.

4.17 DENTAL SURGICAL PROCEDURES

General dental services are not covered, but limited oral Surgical Procedures are covered when performed in a Provider's office or in an inpatient or outpatient setting. If you are unable to undergo dental Treatment in a dental office or under local anesthesia due to a documented physical, mental, or medical reason, you have coverage for Medically Appropriate, non-dental related services to the dental Treatment. The following Covered Services may require Pre-Notification by UnitedHealthcare:

1. Treatment for accidental Injury to Sound Natural Adult Teeth, the jaw bones or surrounding tissues, not caused by biting or chewing, when initial Treatment is sought within 24 hours of the accident and completed within 24 months of the initial Treatment or when Care Coordination is notified within 6 months of the Injury. "Sound Natural Adult Teeth" means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.
2. Treatment or correction of a non-dental physiological condition which has resulted in severe functional impairment.
3. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
4. Diagnostic and surgical Treatment of conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology.

4.18 COSMETIC, RECONSTRUCTIVE, OR PLASTIC SURGERY

Coverage will be the same as for Treatment of any other physical Illness generally and may require Pre-Notification by UnitedHealthcare. Covered Services are limited to the following:

1. Surgery to correct a defect resulting from accidental Injury when initial Treatment is sought or Pre-approved within six months of the initial Treatment.
2. Surgery to correct a functional defect which results from a Congenital Anomaly and/or acquired disease or anomaly.

3. Surgical reconstruction of the breast following a mastectomy, and surgical reconstruction of the other breast to achieve a symmetrical appearance.
4. Reconstructive Surgery for Craniofacial Abnormalities for a Member under age 18.
5. Breast reduction when Medically Appropriate and pre-approved by the Plan Administrator.

4.19 ALLERGY CARE

Covered Services for testing and Treatment can be provided by a PCP or Specialist.

4.20 DIABETES CARE

Diabetic and Pre-Diabetic Counseling. Covered Services, which may require pre-authorization, include instructions enabling a person with diabetes and/or his caretaker to understand the care and management of diabetes; development of an individualized management plan; nutritional counseling and proper use of diabetes equipment and supplies. Diabetes self-management training is provided at these times:

1. The initial diagnosis of diabetes.
2. A significant change in symptoms or condition that requires changes in your self-management regime, as diagnosed by an In-Network Physician or practitioner.
3. The prescription of periodic or episodic continuing education warranted by the development of new techniques and Treatments for diabetes.
4. The need for a caretaker or a change in caretakers for the person with diabetes necessitates diabetes management training for the caretaker.

4.21 DIABETES EQUIPMENT AND SUPPLIES

Diabetes supplies include, but are not limited to: blood glucose monitors; test strips specified for use with a corresponding blood glucose monitor; visual reading and urine test strips and tablets that test for glucose, ketones, and protein; lancets and lancet devices; injection aids, including devices used to assist with insulin injection and needleless systems; and glucagon emergency kits.

Diabetes equipment includes insulin pumps and necessary accessories; insulin infusion devices and podiatric appliances. Pre-Notification may be required.

Diabetes equipment and supplies also include prescription orders for insulin and insulin analog preparations, insulin syringes, prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and biohazard disposable containers. No claim forms are required.

Diabetes equipment and supplies are covered for the following:

1. Insulin dependent or non-insulin dependent diabetes.
2. Elevated blood glucose levels induced by pregnancy.
3. Another medical condition associated with elevated blood glucose levels.

4.22 PROSTHETIC APPLIANCES/ORTHOTIC DEVICES

The following covered appliances and devices may require Pre-Notification by UnitedHealthcare:

1. Initial Prosthetic Appliances are covered. Limited to one replacement every three years. No limit to replacement due to natural maturation.
2. Initial breast prostheses and two surgical brassieres after 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.

3. Orthopedic braces, such as orthopedic appliances used to support, align, or hold bodily parts in a correct position; crutches, rigid back, leg, or neck braces; casts for Treatment of any part of the legs, arms, shoulders, hips, or back; special surgical and back corsets; and Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints that are custom designed for the purpose of assisting the function of a joint.
4. Shoes that are an integral part of an approved leg brace.
5. Therapeutic shoes for persons with diabetes.
6. Cochlear Implants if hearing loss is related to a Surgical Procedure or Injury.

Must receive Pre-Notification for items over $1,000. Prosthetic Appliances are covered subject to restrictions in the Limitations and Exclusions.

4.23 DURABLE MEDICAL EQUIPMENT (DME)

You must obtain services and devices through an In-Network DME Provider, which may require Pre-Notification by UnitedHealthcare. UnitedHealthcare will determine whether DME is rented or purchased, and retains the option to recover the DME upon cancellation or termination of your coverage.

DME is covered at initial placement and when standard replacements are needed due to physical growth of Members under 18 years of age, and must be consistent with the Medicare DME Manual. The Plan will pay for repair or replacement of equipment once every three years when approved by the Plan Administrator.

Examples of DME are: standard wheelchairs, crutches, walkers, orthopedic tractions, hospital beds, oxygen and related supplies and equipment, bedside commodes, suction machines, etc. The Maximum Allowable Charge for a standard, non-mechanized wheelchair, hospital bed, or walker will be applied to the cost of a mechanized or otherwise non-standard wheelchair, hospital bed, or walker. This Plan does include breast pumps as a Covered Expense under the DME benefit.

Excluded items are listed in Limitations and Exclusions (Section 5).

4.24 DISPOSABLE MEDICAL SUPPLIES

The following medical supplies are covered: ostomy supplies, catheters, compression stockings (two pair per Calendar Year), diabetic supplies and nutritional supplements used with enteral feeding.

4.25 THERAPIES FOR CHILDREN WITH DEVELOPMENTAL DELAYS

Covered Services include Treatment for "Developmental Delays," which means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive, physical, communication, social or emotional, or adaptive.

Treatment includes the necessary rehabilitative and habilitative therapies in accordance with an "Individualized Family Service Plan," which is the initial and ongoing Treatment plan developed and issued by the Interagency Council on Early Childhood Intervention under Chapter 73 of the Human Resources Code for a Dependent child with Developmental Delays, including: Occupational Therapy evaluations and services, Physical Therapy evaluations and services, Speech Therapy evaluations and services, and dietary or nutritional evaluations.

You must submit an Individualized Family Service Plan to UnitedHealthcare before you receive any services, and again if the Individualized Family Service Plan is changed. After a child is three years of age and services under the Individualized Family Service Plan are completed, the standard contractual provisions in this Plan Document and any benefit exclusions or limitations will apply.

4.26 AUTISM SPECTRUM DISORDER

Generally recognized services prescribed in relation to Autism Spectrum Disorder in a Treatment plan recommended by a Physician are available.

Individuals providing Treatment prescribed under that plan must be a health care practitioner: who is licensed, certified, or registered by an appropriate agency of the state of Texas; whose professional credential is recognized and accepted by an appropriate agency of the United States; or who is certified as a Provider under the TRICARE military health system.

Treatment may include services such as: evaluation and assessment services, behavior training and behavior management, Speech Therapy, Occupational Therapy, Physical Therapy, or medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder. Coverage does not include applied behavior analysis.

4.27 CLINICAL TRIALS

Coverage for routine patient costs incurred by a qualifying individual who is participating in an approved Clinical Trial.

4.28 BARIATRIC RESOURCE SERVICES (BRS)

Bariatric Resource Services (BRS) is a surgical weight loss solution for those individual(s) who qualify clinically for bariatric surgery. Specialized Nurses provide support through all stages of the weight loss surgery process. Our program is dedicated to providing support both before and after surgery. Nurse help with decision support in preparation for surgery, information and education important in the selection of a bariatric surgery program, and post-surgery and lifestyle management. Nurses can provide information on the nation's leading obesity surgery centers, known as Centers of Excellence. Access the Bariatric Resource Services Centers of Excellence program at (888) 936-7246.

All authorization information and enrollment for bariatric surgery must be initiated through OptumHealth's Bariatric Resource Services (BRS) Program. Covered participants seeking coverage for bariatric surgery should notify OptumHealth as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center by calling OptumHealth at (888) 936-7246 to enroll in the program.

Morbid Obesity Surgery

The Plan covers surgical Treatment of morbid obesity provided all of the following are true:

1. Covered Person is over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4;
2. Covered Person has a minimum Body Mass Index (BMI) of 40, or > 35 with at least 1 co-morbid condition present;
3. Covered Person must enroll in the OptumHealth Bariatric Resource Services (BRS) program;
4. Covered Person must use an OptumHealth Bariatric Center of Excellence (COE);

5. Covered Person has completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation;
6. 6-month physician supervised diet documented within the last 2 years;
7. One surgery per lifetime unless complications; and
8. Excess skin removal is not covered, unless medically necessary.

All authorization information and enrollment for bariatric surgery must be initiated through OptumHealth's Bariatric Resource Services (BRS) Program. Covered participants seeking coverage for bariatric surgery should notify OptumHealth as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center by calling OptumHealth at (888) 936-7246 to enroll in the program.

Section 5
Limitations and Exclusions

Expenses not covered include the services and supplies described below, regardless of whether they are considered Medically Appropriate or are recommended by a Doctor. Also see Expenses Not Covered under the Prescription Drug Benefits.

1. Services or supplies which in the judgment of the UnitedHealthcare are not Medically Appropriate and essential to the diagnosis or direct care and Treatment of a sickness, Injury, condition, disease, or bodily malfunction as defined herein.
2. If a service is not covered, UnitedHealthcare will not cover any services related to it. Related services are:
    a. Services in preparation for the non-covered service.
    b. Services in connection with providing the non-covered service.
    c. Hospitalization required to perform the non-covered service.
    d. Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
3. Services, supplies, therapies, or procedures determined to be Experimental or Investigational or an Unproven Service by the Plan Administrator. (See Section 13.30.)
4. Radial and hexagonal keratotomies or refractive surgeries, unless required due to a medical condition other than myopia, presbyopia, and astigmatism.
5. Any charges resulting from the failure to keep a scheduled visit with a Provider or for acquisition of medical records.
6. Activities of daily living.
7. Take-home drugs furnished by a Hospital or other facility.
8. Foot orthotics, except for shoes described in Section 4.21 Diabetes Equipment and Supplies.
9. Services of a Christian Science Practitioner.
10. Special medical reports not directly related to Treatment.
11. Paternity DNA Testing.
12. Biofeedback.
13. Rolfing.

14. Services of a massage therapist.
15. Examinations, testing, or other services required by employers, insurers, schools, camps, courts, licensing authorities, other third parties, or for personal travel.
16. Services provided by a person ordinarily residing in the same household or by a close relative of the Covered Person.
17. Services for which the Provider usually does not charge a fee.
18. Charges for educational materials and supplies (e.g. books and videotapes).
19. Claims submitted more than 12 months after the date of service will not be paid. 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.
20. Charges incurred for donating blood.
21. Charges for telephone consultations.
22. Psychotherapy for learning disabilities, including but not limited to ADD, ADHD, dyslexia, and educational deficits.
23. Replacement of eyeglasses or contact lenses prescribed as part of postoperative Treatment.
24. Charges for corrective lenses or frames (except for contact lenses for the Treatment of keratoconus).
25. Charges for telephonic mental health services.
26. Services or supplies for injuries sustained as a result of war, declared or undeclared, or any act of war or while on active or reserve duty in the armed forces of any country or international authority.
27. Benefits for which you are eligible through entitlement programs of the federal, state, or local government, including but not limited to Medicare, Medicaid, or their successors.
28. Care for conditions that federal, state or local law requires to be treated in a public facility.
29. Appearances at court hearings and, other legal proceedings, and any services relating to judicial or administrative proceedings or conducted as part of medical research.
30. Services or supplies provided in connection with an occupational sickness or an Injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
31. Transportation services except as described in Ambulance Services, or when approved by UnitedHealthcare.
32. Personal or comfort items, including but not limited to: televisions, telephones, guest beds, admission kits, maternity kits, and newborn kits provided by a Hospital or other inpatient facility.
33. Private rooms unless Medically Appropriate and authorized by UnitedHealthcare. If a Semi-Private Room is not available, UnitedHealthcare covers a private room until a Semi-Private Room is available.
34. Any and all transplants of organs, cells, and other tissues, except as described in Inpatient Hospital Services (Section 4.3.12).
35. Services or supplies for Custodial Care.

36. Services or supplies furnished by an institution that is primarily a place of rest, a place for the aged, or any similar institution.

37. Private duty nursing on an outpatient basis.

38. Services or supplies for Dietary and Nutritional Services, including home testing kits, vitamins, dietary supplements and replacements, and special food items, except: an inpatient nutritional assessment program provided in and by a Hospital and approved by UnitedHealthcare; as described in Diabetes Care; as described in Autism Spectrum Disorder; as described in Therapies for Children with Developmental Delays; or when used with enteral feeding. Nutritional and dietary supplements, including anorectics used for weight control, infant formula (except for donor breast milk, Enteral feeding, PKU Supplements or Nutritional supplements used to address symptoms of Autism Spectrum Disorder).

39. Surrogate parenting.

40. Services or supplies provided primarily for: environmental sensitivity, or clinical ecology, or any similar Treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists, or inpatient allergy testing or Treatment.

41. Services or supplies provided for, in preparation for, or in conjunction with, the following, except as described in Maternity Care and Family Planning Services: Sterilization reversal (male or female); transsexual surgery and related Treatment, including hormone therapy and medical or psychological counseling; Treatment of sexual dysfunction including medications, penile prostheses, and other surgery, and vascular or plethysmographic studies that are used only for diagnosing impotence; promotion of fertility through extra-coital reproductive technologies including, but not limited to, super ovulation uterine capacitation enhancement, direct-intraperitoneal insemination, trans-uterine tubal insemination, gamete intrafallopian transfer, pronuclear oocyte stage transfer, zygote intrafallopian transfer, and tubal embryo transfer; any services or supplies related to invitro fertilization or other procedures when you are the donor and the recipient is not a Member; and invitro fertilization and fertility drugs.

42. Services or supplies for routine foot care such as hygienic care, Treatment for flat feet or fallen arches, subluxation of the foot, removal of corns or calluses, toenail trimming or non-surgical Treatment of bunions, or ingrown toenails.

43. Services or supplies for reduction of obesity or weight, including Surgical Procedures and prescription drugs, even if the Member has other health conditions which might be helped by a reduction of obesity or weight, unless part of the UHC Bariatric Resource Services program.

44. Services or supplies for, or in conjunction with, chelation therapy, except for Treatment of acute metal poisoning.

45. Services or supplies for dental care, except as described in Dental Surgical Procedures, (Section 4.17).

46. Services or supplies for orthognathic surgery after the Member's 19th birthday, except as may be provided under Dental Surgical Procedures, (Section 4.17). Orthognathic surgery includes, but is not limited to, correction of congenital, developmental or acquired maxillofacial skeletal deformities of the mandible and maxilla.

47. Non-surgical or non-diagnostic services or supplies for Treatment or related services to the temporomandibular (jaw) joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction

of the temporomandibular joint and all adjacent or related muscles and nerves. Medically Appropriate diagnostic and/or surgical Treatment is covered for conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, trauma, congenital defect, developmental defect or pathology, as described in Dental Surgical Procedures, (Section 4.17).

48. Alternative Treatments such as: acupressure, hypnotism, massage therapy, and aroma therapy.
49. Services or supplies for: video fluoroscopy, intersegmental traction, surface EMGs, manipulation under anesthesia, and muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph, and Dynatron.
50. Galvanic stimulators or TENS units.
51. Disposable or consumable outpatient supplies such as syringes, needles, blood or urine testing supplies (except as used in the Treatment of diabetes), sheaths, elastic garments, stockings (except compression stockings), bandages, and garter belts.
52. Prosthetic Appliances or orthotic devices not described in Diabetes Care or Prosthetic Appliances and Orthotic Devices including, but not limited to: orthodontic or other dental appliances or dentures; splints or bandages provided by a Physician in a non-Hospital setting or purchased over the counter for the support of strains and sprains; corrective orthopedic shoes, including those which are a separable part of a covered brace; specially-ordered, custom-made or built-up shoes and cast shoes; shoe inserts designed to support the arch or effect changes in the foot or foot alignment; arch supports; orthotics; braces; splints or other foot care items and wigs.
53. Educational therapy, including the Treatment of learning disabilities, developmental delays in speech, motor or language skills, behavioral disorders including adolescent behavior disorders such as conduct or oppositional disorders or services that are educational in nature or are for vocational testing or training, except as may be provided under Autism Spectrum Disorder. This exclusion does not apply to developmental delays if the delay is related to a treatable medical condition.
54. Behavior modification services.
55. Any Medical Social Services; any outpatient family counseling and/or therapy, bereavement counseling (except as provided as Hospice Care), vocational counseling, pastoral counseling, or Marriage and Family Therapy and/or counseling.
56. Mental health services except as described in Mental Health Care Services or as may be provided under Autism Spectrum Disorder.
57. Residential Treatment.
58. Trauma or wilderness programs for behavioral health or Chemical Dependency Treatment.
59. Purchase of or replacement for loss, damage, or functional defect of hearing aids. Batteries are not covered unless needed at the time of the initial placement of the hearing aid device(s).
60. Deluxe equipment such as motor driven wheelchairs, scooters and beds. The Maximum Allowable Charge for a standard, non-mechanized wheelchair, hospital bed, or walker will be applied to the cost of a mechanized or otherwise non-standard wheelchair, hospital bed, or walker.

61. Equipment such as comfort items; bed boards; bathtub lifts; over-bed tables; air purifiers; sauna baths; exercise equipment; stethoscopes and sphygmomanometers; air conditioners; air filters; blood pressure monitoring devices; commodes; electrical stimulators; heat lamps; lumbar supports; massage devices; TENS units; whirlpools and Experimental and/or research items. This list is not all-inclusive. Verification for items not listed may be obtained through the Plan Administrator.
62. Over-the-counter supplies or medicines and prescription drugs and medications of any kind, except as provided while confined as an inpatient or under Autism Spectrum Disorder, or if covered under the Prescription Drug Program.
63. Health services and supplies that do not meet the definition of Covered Expenses (Section 13.17).
64. Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations (other than immunizations for which Benefits are required by Texas law), or Treatments that are otherwise covered under the Policy when: related to judicial or administrative proceedings or orders, conducted for purposes of medical research, required to obtain or maintain a license of any type.
65. Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising before the date your coverage under the Policy ends.
66. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. This exclusion does not apply to Medicaid or tax-supported mental institutions.
67. In the event that an Out-of-Network Provider waives Coinsurance and/or Calendar Year Deductible for a particular health service, no Benefits are provided for the health service for which the Coinsurance and/or Calendar Year Deductible are waived. This exclusion does not apply to Medicaid or tax-supported mental institutions.
68. Charges in excess of Eligible Expenses or in excess of any specified limitation.
69. Domiciliary care.
70. Respite care.
71. Rest cures.
72. Psychosurgery.
73. Medical and surgical Treatment of excessive sweating (hyperhidrosis).
74. Medical and surgical Treatment for snoring, except when provided as a part of Treatment for documented obstructive sleep apnea.
75. Oral appliances for snoring.
76. Vein ligation/stripping.
77. Reduction mammoplasty (except when Medically Appropriate and pre-approved by the Plan Administrator).
78. Scar revision for keloids.
79. Applied behavior analysis.

Section 6
Prescription Drug Program

6.1 DEFINITIONS

In addition to the applicable terms provided in the Definitions section of this Plan Document, the following terms will apply specifically to the Prescription Drug Program.

1. Allowable Amount. The maximum amount determined by UnitedHealthcare to be eligible for consideration of payment for a particular covered drug. As applied to In-Network Pharmacies and the mail service Prescription Drug Program, the Allowable Amount is based on the provisions of the contract between UnitedHealthcare and the In-Network Pharmacy or Pharmacy for the mail service Prescription Drug Program in effect on the date of service.
2. Compound Drugs. Those drugs that have been measured and mixed with U.S. Food and Drug Administration (FDA) approved pharmaceutical ingredients by a pharmacist to produce a unique formulation that is Medically Appropriate because commercial products either do not exist or do not exist in the correct dosage, size, or form. The drugs used must meet the following requirements:
   a. The drugs in the compounded product are FDA approved.
   b. The approved product has an assigned National Drug Code (NDC).
   c. The primary active ingredient is a covered drug under the Prescription Drug Program.
   d. Compound Drugs over $250 are subject to Prior Authorization.
3. Coinsurance. The amount paid by the Member for each Prescription Order filled or refilled through an In-Network Pharmacy or through the mail service Prescription Drug Program.
4. Day Supply. The number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety.
5. Generic Drug. A drug that has the same active ingredient as the brand name drug and is allowed to be produced after the brand name drug's patent has expired. In determining the brand or generic classification for covered drugs, UnitedHealthcare utilizes the generic/brand status assigned by a nationally recognized Provider of drug product database information.
6. Legend Drug. A drug, biological, or compounded prescription which is required by law to have a label stating "Caution − Federal Law Prohibits Dispensing Without a Prescription," and which is approved by the FDA for a particular use or purpose.
7. National Drug Code (NDC). A national classification system for the identification of drugs.
8. In-Network Pharmacy. An independent retail Pharmacy or chain of retail Pharmacies which have entered into an agreement with UnitedHealthcare to provide pharmaceutical services to Members under the Prescription Drug Program.
9. Pharmacy. A state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he/she practices.
10. Prescription Order. A written or verbal order from a Physician or authorized Health Care Professional to a pharmacist for a drug or device to be dispensed.

6.2 HOW THE PROGRAM WORKS

This portion of the Plan Document explains coverage for Medically Appropriate covered drugs prescribed to treat you for a chronic, disabling, or life-threatening Illness covered by UnitedHealthcare if the drug has been approved by the FDA for at least one indication and is recognized by the following for Treatment of the indication for which the drug is prescribed: a prescription drug reference compendium approved by the Texas Department of Insurance or substantially accepted peer-reviewed medical literature.

1. As new drugs are approved by the FDA, such drugs, unless the intended use is specifically excluded by UnitedHealthcare, are eligible for benefits.
2. When you need a Prescription Order filled, you can use an In-Network Pharmacy or the mail service prescription drug program. Each prescription or refill is subject to the Coinsurance in the Schedule of Benefits, payable by Member directly to the In-Network Pharmacy or the mail service Pharmacy.
3. When you go to an In-Network Pharmacy, you must pay the Coinsurance. You may be required to pay for limited or non-Covered Services. No claim forms are required. If you are unsure whether a Pharmacy is an In-Network Pharmacy, you may access the Website at www.myuhc.com or contact customer service at the toll-free number on your identification card.
4. If you elect to use the mail service prescription drug program, you must mail your Prescription Order to the address provided on the mail service prescription drug claim form and send in your payment for each prescription filled or refilled. Each prescription or refill is subject to the Coinsurance in the Schedule of Benefits payable by the Member, directly to the mail order Pharmacy.
5. If you have any questions about the mail service prescription drug program, need assistance in determining the amount of your payment, or need to obtain the mail service prescription drug claim form, you may access the Website at www.myuhc.com or contact customer service at the toll-free number on your identification card. When you mail Prescription Orders to the address on the mail service prescription drug claim form, you must send in your payment.
6. If the Allowable Amount of the drug is less than the Coinsurance, you pay the lower cost.
7. UnitedHealthcare will determine the Day Supply at its sole discretion. Quantities of some drugs are restricted regardless of the quantity ordered by the Physician.
8. Formulas for the Treatment of phenylketonuria are Dietary formulas necessary for the Treatment of phenylketonuria.
9. Diabetes Supplies for Diabetes Care are covered. Examples include: insulin, insulin analogs, insulin pens, insulin syringes, needles, injection devices, glucagon emergency kits, lancets, lancet devices, test strips specified for use with a corresponding blood glucose monitor, visual reading strips and urine and blood testing strips, and tablets which test for glucose, ketones, and protein, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels. You must pay the applicable Prescription Drug Program Coinsurance in the Schedule of Benefits. No claim forms are required.

6.3 EXCLUSIONS

The benefits of the Prescription Drug Program are not available for:

1. Drugs which by law do not require a Prescription Order from a Physician or authorized Health Care Professional (except insulin, insulin analogs, insulin pens, and prescriptive and

non-prescriptive oral agents for controlling blood sugar levels); and drugs, insulin, or covered devices for which no valid Prescription Order is obtained, or for nicotine replacements, unless the Covered Person has attended a smoking cessation seminar conducted by the City of Austin's Employee Assistance Program.

2. Drugs that are not Federal Legend Drugs.
3. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use.
4. Prescriptions payable under workers' compensation or similar regulations.
5. Immunization agents (except shingles vaccines), biological sera, blood, and blood plasma.
6. Drugs required by law to be labeled: "Caution Limited by Federal Law to Investigational Use," or Experimental drugs, even though a charge is made for the drugs.
7. Drugs, that the use or intended use of would be illegal, unethical, imprudent, abusive, not Medically Appropriate, or otherwise improper.
8. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
9. Drugs used or intended to be used in the Treatment of a condition, sickness, disease, Injury, or bodily malfunction that is not covered under the Plan.
10. Drugs dispensed in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
11. Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Coinsurance.
12. Drugs purchased from an Out-of-Network Pharmacy.
13. Any special services provided by a Pharmacy, including but not limited to counseling and delivery, except as described in Section 4, Diabetes Care and Diabetes Equipment and Supplies.
14. Drugs dispensed in quantities in excess of the Day Supply amounts indicated in the Schedule of Benefits, or refills of any prescriptions in excess of the number of refills specified by the Physician or authorized Health Care Professional or by law, or any drugs or medicines dispensed more than one year after the Prescription Order date.
15. Administration or injection of any drugs (except shingles vaccines).
16. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
17. Combinations of Federal Legend Drugs in a non-FDA approved dosage form.
18. Non-disposable auto-injectors except for insulin.
19. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous, intramuscular, intrathecal, intraarticular injection, or gastrointestinal (enteral) infusion in the home setting.
20. Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative) and minerals.

21. Nutritional and dietary supplements, including anorectics used for weight control (except Phenylketonuria [PKU] Supplements).
22. Allergy serum and allergy testing materials. However, you do have certain benefits available under Allergy Care in Covered Services and Benefits.
23. Athletic performance enhancement drugs.
24. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the Treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
25. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
26. Drugs prescribed for non-FDA approved indications (off-label), unless pre-approved by the Plan Administrator.
27. Over-the-counter drugs except for smoking replacement therapy.
28. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
29. Drugs prescribed and dispensed for the Treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
30. Drugs for treatment of erectile dysfunction or sexual dysfunction.
31. Drugs for the Treatment of Infertility (oral and injectable).

6.4 HOW TO APPLY FOR AN EXCEPTION

If an excluded drug is prescribed for a specific medical condition, you may qualify for an exception. To request an exception, submit a letter to UnitedHealthcare from your Doctor stating the medical condition that requires the non-covered drug and the length of projected use. The maximum time for which a letter can justify an exception is 12 months. If your exception is approved, you will be able to purchase your prescription at your local network pharmacy or by mail order by paying the applicable Coinsurance amount.

To request the exception, submit the Doctor's letter to UnitedHealthcare Appeals, PO Box 740816, Atlanta, GA 30374. If your request for an exception is denied, see Section 11, Complaint and Appeal Procedures, for information regarding the appeals options that are available to you.

Section 7
Vision Exam Services

Vision exams are subject to the limitations set forth in the Schedule of Benefits.

7.1 BENEFIT

You are entitled to one vision examination, including refraction and glaucoma screening every calendar year. Such exam may be either for eyeglasses or contact lenses. To be covered, the exam must be provided by an In-Network Vision Provider. "In-Network Vision Provider" means a Provider of vision services licensed as required by the state who has contracted with UnitedHealthcare to provide vision services to Members.

7.2 LIMITATIONS AND EXCLUSIONS

Benefits are not provided for the following:

1. Eyeglass lenses, eyeglass frames, or contact lenses.
2. Treatment of the eyes or any special, therapeutic, or diagnostic procedures.
3. Eye examinations required by an employer.
4. Services for which no charge is made.

Section 8
Eligibility

8.1 EFFECTIVE DATE

The City will determine Effective Dates for Covered Persons enrolled in the Plan. These Effective Dates are outlined in the *Guide* issued annually.

8.2 DOCUMENTATION

Documentation verifying Dependent status must be presented with the application for Coverage. The list of acceptable documents is listed in the *Guide* issued annually.

8.3 OPEN ENROLLMENT

Eligible Employees and COBRA participants have the opportunity to change coverage for themselves and their eligible Dependents during Open Enrollment. Changes made during Open Enrollment are effective January 1 of the next year.

8.4 TERMINATION DATE

The City will determine Termination Dates for Covered Persons enrolled in the Plan. These Termination Dates are outlined in the *Guide* issued annually.

8.5 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The City shall enroll for immediate Coverage under this Plan anyone who is the subject of a QMCSO, administrative writ, or the equivalent under state law if such individual is not already covered by the Plan as an eligible Dependent.

8.6 BENEFITS CONTINUATION

The following is a summary of the major requirements of Federal law, State law, or City provisions that provide for the extension of benefits to certain classes of Employees and Dependents after Coverage otherwise would terminate.

8.7 COBRA CONTINUATION OF COVERAGE

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, the following provisions apply with respect to benefits continuation under the Plan:

1. Employees and their eligible Dependents who lose Coverage due to a qualifying event as defined in this subsection will be eligible for COBRA coverage for 18 months from the date of the qualifying event. A qualifying event is defined as the termination of employment of the covered Employee (except for reasons of gross misconduct), a reduction in a covered Employee's hours of employment, or a change in the Employee's work status.
2. If a Covered Person is determined under Old Age, Survivors and Disability Insurance, or Supplemental Security Income to have been disabled at the time the qualifying event occurred, or at any time during the first 60 days of COBRA coverage, COBRA coverage

may be extended for the person so disabled and any other covered family members who also are qualified beneficiaries for 11 months in addition to the 18 months. The Covered Person is responsible for notifying the COBRA Administrator of such determination, within 60 days after the date of the determination, and for notifying the COBRA Administrator within 30 days after the date of any final determination under such title or titles that the Covered Person is no longer disabled. In order for the disabled person and any other covered family members to be eligible for the additional 11 months, the disabled person must meet the requirements of this paragraph before the first 18 months of COBRA coverage have expired.

3. Dependents of active Employees who lose Coverage due to a qualifying event as defined in this subsection will be eligible for COBRA coverage for 36 months from the date of the qualifying event. A qualifying event is defined as the death of the covered Employee, the divorce or legal separation of the covered Employee from the Employee's Spouse, the Employee's becoming eligible for Medicare, or the cessation of a Dependent child's Coverage because the child no longer meets the definition of eligible Dependent under the terms of the Plan. Employees must notify the Employee Benefits Division of the Human Resources Department of a Dependent child's loss of eligibility because he or she no longer meets the definition of an eligible Dependent under the plan within 60 days of the event.
4. To ensure COBRA coverage, a COBRA Enrollment Form must be completed and signed within 60 days of the qualifying event or the date of the COBRA notification letter sent from the COBRA Administrator. The first COBRA payment for continuation coverage must be made in full not later than 45 days after the date of the election. Subsequent monthly payments are due on the first day of the month with a grace period of 30 days, after which coverage will be terminated and not eligible for reinstatement.
5. COBRA coverage may end before the full period described above. COBRA coverage will end on the first to occur of the following events if any of these events occur before the end of the COBRA eligibility period:
    a) The City ceases to offer any group health plan to any Employee.
    b) The Covered Person fails to make timely payment of a required contribution.
    c) The Covered Person becomes covered under another group health plan, unless coverage under the new plan contains an exclusion or limitation with respect to any pre-existing condition of the Covered Person, and the exclusion or limitation is not prohibited by Federal law.
    d) The Covered Person becomes entitled to Medicare benefits.
    e) The Covered Person becomes covered in the Federally facilitated marketplace.

8.8 USERRA CONTINUATION OF COVERAGE

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), Employees who are required to be absent from work due to voluntary or involuntary military service or training have the right to continue Coverage under this Plan for up to 18 months from the date Coverage otherwise would end, provided they pay the amount they would pay if they were an Active Employee.

8.9 SURVIVING FAMILY/WORK-RELATED MEDICAL COVERAGE

A Dependent who is covered under the Plan at the time the covered Employee is killed in the line of duty will be allowed to continue Coverage provided the Employee's death is ruled compensable under the City's Workers' Compensation program.

To ensure continuation of Coverage, an enrollment application must be completed and signed within 90 days of the Employee's date of death.

Surviving Family/Work-Related Medical Coverage may be terminated on the first to occur of the following events:

1. The City ceases to offer any group health plan to any Employee.
2. The Dependent fails to make timely payment of a required contribution.
3. The date the Dependent is eligible for a group health plan through another employer.
4. In the case of a Spouse, the date the Spouse remarries or is eligible for Medicare.
5. In the case of a child, the date the child no longer meets the definition of Dependent under the Plan.

8.10 CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

The following provisions apply with respect to benefits continuation for Domestic Partners under the Plan:

1. Eligible Domestic Partners who lose Coverage due to a qualifying event as defined in this subsection will be eligible for continuation of coverage for 18 months from the date of the qualifying event. A qualifying event is defined as the termination of employment of the covered Employee (except for reasons of gross misconduct), a reduction in a covered Employee's hours of employment, or a change in the Employee's work status.
2. If a Covered Person is determined under Old Age, Survivors and Disability Insurance, or Supplemental Security Income to have been disabled at the time the qualifying event occurred, or at any time during the first 60 days of continuation of coverage, continuation of coverage may be extended for the person so disabled and any other covered family members who also are qualified beneficiaries for 11 months in addition to the 18 months. The Covered Person is responsible for notifying the COBRA Administrator of such determination, within 60 days after the date of the determination, and for notifying the COBRA Administrator within 30 days after the date of any final determination under such title or titles that the Covered Person is no longer disabled. In order for the disabled person and any other covered family members to be eligible for the additional 11 months, the disabled person must meet the requirements of this paragraph before the first 18 months of continuation of coverage have expired.
3. Dependents of active Employees who lose Coverage due to a qualifying event as defined in this subsection will be eligible for continuation of coverage for 36 months from the date of the qualifying event. A qualifying event is defined as the death of the covered Employee, dissolution of the Domestic Partnership, the Employee becoming eligible for Medicare, or the cessation of a Dependent child's Coverage because the child no longer meets the definition of eligible Dependent under the terms of the Plan.
4. To ensure continuation of coverage, a Continuation of Coverage Enrollment Form must be completed and signed within 60 days of the qualifying event or the date of the continuation of coverage notification letter sent from the COBRA Administrator. The first payment for continuation of coverage must be made in full not later than 45 days after the date of the election. Subsequent monthly payments are due on the first day of the month with a grace period of 30 days, after which coverage will be terminated and not eligible for reinstatement.
5. Continuation of coverage may end before the full period described above. Continuation of coverage will end on the first to occur of the following events if any of these events occur before the end of the continuation of coverage eligibility period:

a. The City ceases to offer any group health plan to any Employee.

b. The Covered Person fails to make timely payment of a required contribution.

c. The Covered Person becomes covered under another group health plan, unless coverage under the new plan contains an exclusion or limitation with respect to any pre-existing condition of the Covered Person, and the exclusion or limitation is not prohibited by Federal law.

d. The Covered Person becomes entitled to Medicare benefits.

e. The Covered Person becomes covered in the Federally facilitated Marketplace.

Section 9
Coordination of Benefits

9.1 EFFECT OF COVERAGE UNDER OTHER PLANS

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

When this Plan is secondary, payment determination will be made after the Plan Administrator receives an Explanation of Benefits (EOB) from the Primary Plan. First, this Plan will determine its obligation to pay or provide benefits without regard to any Other Plan (what this Plan would pay if there were no other coverage). If there is a patient responsibility under the Primary Plan, then this Plan will reimburse that responsibility not to exceed the amount this Plan would have paid in the absence of other coverage.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

Determining the allowable expense if this Plan is secondary:

If this Plan is secondary and the expense meets the definition of a Covered Service under this Plan, 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.

When the Provider is an In-Network Provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the Provider is an In-Network Provider for the primary plan and an Out-of-Network Provider for this Plan, the allowable expense is the primary plan's network rate. When the Provider is an Out-of-Network Provider for the primary plan and an In-Network Provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the Provider is an Out-of-Network Provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

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

9.2 ORDER OF BENEFITS

Other Plan benefits will be ignored for the purposes of determining the benefits payable by the Plan if the rules set forth in the paragraphs below require this Plan to determine its benefits before such Other Plan. The services due or the benefits payable under this Plan will be reduced in accordance with the following:

1. When the Other Plan does not have a Coordination of Benefits provision, the Other Plan is primary.
2. When the Other Plan does have a Coordination of Benefits provision, the following rules govern:
    a. The plan that covers the Covered Person as an Employee must determine its benefits first.
    b. If (2)(a) does not apply, the plan which covers the Dependent child of the parent who is born earlier in the year (year of birth is not taken into account) will determine its benefits first, EXCEPT that when a claim is made for a Dependent child of divorced or separated parents, the following rules will apply:
        1) A plan that covers a child as a Dependent of a parent who, by court order must provide health coverage, will determine its benefits first.
        2) When there is no court order which requires a parent to provide health coverage to a Dependent child, the following rules apply:
            A. When a parent who has custody of the child has not remarried, the custodial parent's plan will determine its benefits first.
            B. When a parent who has custody of the child has remarried:
                I. The custodial parent's plan will determine its benefits first.
                II. The stepparent's plan will determine its benefits next.
                III. The plan of the parent without custody will determine its benefits third.
            C. If none of the above rules apply, the plan that has covered the Dependent child for a longer period of time will determine its benefits first.
3. Where part of the Other Plan coordinates benefits and a part does not, each part will be treated as a separate plan.
4. When a Covered Person has Medicare as primary coverage, benefits under this Plan are payable according to the provisions described in Section 9.6, Effects of Medicare.

When the above provisions operate to reduce the total amount of benefits otherwise payable on behalf of a Covered Person under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision will be reduced proportionately, and such reduced amount will be charged against any applicable benefit maximum of this Plan.

9.3 RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purpose of determining the applicability of and implementing the terms of Section 9.1, Effect of Coverage under Other Plans, and Section 9.2, Order of Benefits, of this Plan or a similar provision of any Other Plan, the Plan Administrator may release to, or obtain from, any other insurance company or other organization or individual, any information concerning any individual, which the Plan Administrator considers to be necessary for those purposes.

The City and Plan Administrator will be free from any liability that might arise in relation to such action. Any individual claiming benefits under this Plan will furnish to the Plan Administrator the information that may be necessary to implement the above provisions.

9.4 PAYMENT TO THIRD PARTY

Whenever payments which should have been made under this Plan in accordance with Section 9.1, Effect of Coverage under Other Plans, and Section 9.2, Order of Benefits, have been made under any Other Plan, the Plan Administrator will have the right to pay to any organizations making these payments any amount it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, the Plan Administrator and the City will be fully discharged from liability under this Plan.

9.5 SUBROGATION (THIRD PARTY RECOVERY)

The Plan will be subrogated to, and shall succeed to, any and all rights of recovery from any or all third party parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on the Covered Person's behalf relating to any condition, Illness, or Injury caused by such third party or for which any third party may be liable. This right of subrogation is limited to the extent of benefits payable under this Plan for such condition, Illness, or Injury. Upon payment of such benefits:

1. Each Covered Person or his or her legal guardian agrees, as a condition of receiving benefits under the Plan, to reimburse the Plan 100% of amounts paid for such claims out of any moneys recovered from any third party as the result of judgment, settlement, or otherwise. In addition, each Covered Person agrees to assist the Plan Administrator in enforcing these rights.
2. The Plan Administrator will be entitled to institute an action in the name of such Covered Person or to join in an action brought by such Covered Person against such third party and to participate in any judgment, award, or settlement to the extent of its interest.
3. Such Covered Person will execute such instruments which are necessary for the Plan Administrator to protect its rights of subrogation and will refrain from taking any action which may prejudice the Plan's right of subrogation. Payment by the Plan of any benefits prior to, or without obtaining signed subrogation reimbursement agreement(s), shall not operate as a waiver of this subrogation right. The subrogation reimbursement agreement(s) shall be in a form prescribed by the Plan Administrator.

The Covered Person agrees that, should the Covered Person make or file a claim, demand, lawsuit, or other proceeding against a third party who may be liable for the amount of benefits covered or paid by the Plan, the Covered Person shall, as part of such claim, demand, lawsuit, or other proceeding, and on behalf of the Plan, also seek payment or reimbursement for the amount of such benefits covered or paid by the Plan.

The Covered Person agrees to notify the Plan Administrator prior to making or filing any such claim, demand, lawsuit, or other proceeding. The Plan Administrator may, at that time or any time, instruct the Covered Person not to seek, or to discontinue seeking, payment or reimbursement on behalf of the Plan, and the Plan Administrator may pursue such payment or reimbursement independently in the same or in a separate lawsuit or other proceeding or may abandon such payment or reimbursement altogether, in its sole discretion.

The following persons and entities are considered third parties:

1. 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;

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

As a Covered Person, you agree to the following:

1. the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical Providers, including but not limited to Hospitals or emergency Treatment facilities, that assert a right to payment from funds you recover from a third party.
2. 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.
3. 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.
4. Benefits paid by the Plan may also be considered to be Benefits advanced.
5. 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:
    a. complying with the terms of this section;
    b. providing any relevant information requested;
    c. signing and/or delivering documents at its request;
    d. 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;
    e. responding to requests for information about any accident or injuries;
    f. appearing at medical examinations and legal proceedings, such as depositions or hearings; and
    g. obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

6. 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.
7. 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.
8. you may not accept any settlement that does not fully reimburse the Plan, without its written approval.
9. 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.
10. the Plan's rights will not be reduced due to your own negligence.
11. 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.
12. 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.
13. 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.
14. 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.
15. 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.
16. the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

9.6 EFFECTS OF MEDICARE

This Plan will be the primary Provider of Coverage for any Active Employee or Dependent of an Active Employee who is eligible for Medicare and who is a Covered Person by virtue of an eligible Employee's current employment with the City.

This Plan will be the primary Provider of Coverage for totally disabled Employees who are actively employed and Dependents of actively employed Employees who are Covered Persons while entitled to disability benefits under Social Security.

If any Covered Person is eligible for Medicare benefits because of End Stage Renal Disease, this Plan will be primary and Medicare will be the secondary Provider of coverage as determined by current Medicare guidelines.

Medicare will be the primary Provider of coverage for any Retired Employee who is eligible for Medicare. Medicare will be the primary Provider of coverage for any Medicare-eligible

Dependent of a Retired Employee. If a Retired Employee has a Dependent who is not eligible for Medicare, the Plan will be the primary Provider of Coverage for that Dependent.

For Covered Persons where Medicare is the primary payor of benefits, the Medical Benefits of this Plan will be determined as though the Covered Person has both Part A (Hospital) and the voluntary Part B (non-Hospital) benefits of Medicare. If a Covered Person is not enrolled in Medicare Part A or B, the claim will be paid as if the Covered Person has both A and B coverage.

If a Covered Person under this Plan also is covered or eligible to be covered under Title XVIII of the Social Security Act of 1965, as amended (Medicare Parts A, B, C or D), as primary coverage, benefits are paid according to the Coordination of Benefits method defined in Section 9.2, Order of Benefits. The Plan will pay the difference between Medicare benefits payments and billed charges up to the Maximum Allowable Charge under the Plan.

9.7 COORDINATION WITH STATE PLANS

Payment for benefits with respect to a Covered Person under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Covered Person or a beneficiary of the Covered Person, as required by a state plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid) pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

For purposes of enrollment, benefit determinations, and payments under the Plan, the fact that an individual is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid) will not be taken into account.

To the extent that payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid) in any case in which this Plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Covered Person to such payment for items or services.

Section 10
HIPAA Privacy Protection of Certain Health Information

The Privacy Rule established by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Rule) provides comprehensive federal protection for the privacy of individually identifiable health information. This protection is in addition to confidentiality and privacy protections provided by State law.

The Plan is a covered health care component of the City under HIPAA, and is therefore required to comply with the HIPAA Privacy Rule. The HIPAA Privacy Rule imposes limitations on the permissible uses and disclosures of a Covered Person's Protected Health Information (PHI), and provides certain rights to individuals regarding their PHI. In this document, the term “Protected Health Information” or “PHI” means individually identifiable information, maintained in any form or medium that relates to the past, present, or future physical or mental condition of a Covered Person, the provision of health care to a Covered Person, or the payment for the provision of health care to a Covered Person.

10.1 PERMITTED AND REQUIRED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BY PLAN SPONSOR

As Plan Sponsor, the Employee Benefits Division (EBD) of the Human Resources Department may use or disclose PHI, without the consent of a Covered Person as follows:

1. Payment and Operations.
2. Verification of eligibility for the Plan.
3. Payment histories of Covered Persons with claims expenditures in excess of $75,000 in a Calendar Year.
4. In assisting the benefits consultant in estimating future claims expenditures.
5. Drug payment information for retirees with Medicare for requesting Medicare subsidy or reimbursement under the Early Retiree Reinsurance Program.

10.2 DISCLOSURES OF PHI TO PLAN SPONSOR

The Plan Administrator will disclose PHI to the Plan Sponsor only upon receipt of the certification by the Plan Sponsor that the Plan Document has been amended to incorporate the following provisions, which are hereby incorporated into the Plan Document.

The Plan Sponsor hereby agrees:

1. Not to use or disclose PHI other than as permitted or required by the Plan Document or as required by law.
2. To ensure that any agents, including any subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.
3. To report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for, of which the Plan Sponsor becomes aware.
4. To make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.
5. Not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plans.
6. If feasible, to destroy all PHI received from the Plan that the Plan Sponsor retains in any form and retain no copies of the PHI when no longer needed for the purpose for which disclosure was made, except that if such destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the destruction of the information feasible.

10.3 INDIVIDUAL RIGHTS REGARDING PHI

The Plan Sponsor further agrees to enforce the following rights of Covered Persons, as required by the HIPAA Privacy Rule.

1. Access To Protected Health Information

With limited exceptions, a Covered Person has a right of access to inspect and obtain a copy of his or her PHI that is maintained by the Plan Sponsor. The request must be acted on within 30 days of the date it is received. The request should be submitted, in writing, to the Human

Resources Department (HRD) HIPAA Coordinator. The HRD HIPAA Coordinator should also be contacted to schedule a time to review PHI.

2. Request for Amendment

With limited exceptions, a Covered Person has the right to request an amendment to his/her PHI. A request for amendment may be denied only for limited reasons specified in the HIPAA Privacy Rule. Contact the HRD HIPAA Coordinator to request an amendment to PHI. The request must be in writing and must specify the PHI to be amended and include the reason to support the requested amendment.

3. Accounting of Certain Disclosures

If the Plan Sponsor discloses PHI for any reason other than those described above or those made in response to an authorization signed by the Covered Person or the Covered Person's legally authorized representative, the Covered Person has a right, with limited exceptions, to receive an accounting of disclosures made by the Plan Sponsor. Contact the HRD HIPAA Coordinator to request an accounting of disclosures of PHI.

10.4 LIMITATIONS ON ACCESS TO PHI

Access to a Covered Person's PHI will be limited to the Employees or classes of Employees and contractors described below, and the scope of access will be limited to the minimum amount necessary to accomplish the purpose for which access is required.

1. Benefits Financial Analyst for actuarial purposes.
2. Managers responsible for the Human Resources Department, if necessary, to review actions of contractors or members of the Human Resources Department who have access to PHI.
3. Members of the City Law Department, if needed to provide legal counsel.
4. Members of the City Auditor's Office for use in auditing the performance of the Plan, the Plan Sponsor, or contractors of the Plan Sponsor.
5. Benefits consultant for actuarial analysis.

Access to and use by such Employees or contractors shall also be restricted to the plan administration functions that the Plan Sponsor performs for the Plan. Should an Employee use or disclose PHI for any reason other than described above, the violation will be reported to the Manager of the Employee Benefits Division (EBD) who will report the incident to the Director of the City's Human Resources Department and the Department HIPAA Coordinator for investigation and, if appropriate, disciplinary action. Should an Employee other than those listed above inadvertently receive PHI from UnitedHealthcare, the Manager of EBD will report the incident to the Department HIPAA Coordinator, notify UnitedHealthcare of the infraction, and take appropriate action in accordance with the terms of the contract with UnitedHealthcare. If a Covered Person has any questions regarding the HIPAA Privacy Rule and the Plan, or believes his or her HIPAA privacy rights have been violated, you can contact the Secretary of the U.S. Department of Health and Human Services or you can contact the HRD HIPAA Coordinator:

City of Austin Human Resources Department HIPAA Coordinator
P.O. Box 1088
Austin, TX 78767
(512) 974-3284

Section 11
Complaint and Appeal Procedures

11.1 CUSTOMER INQUIRIES

You or a designated representative may direct inquiries to a UnitedHealthcare customer service representative by mail or by calling the toll-free telephone number on the back of your ID card. Inquiries resolved to your satisfaction will be tracked by UnitedHealthcare. If an inquiry is not resolved promptly to your satisfaction, it will be handled according to the Complaint procedure described below.

11.2 HOW TO FILE A COMPLAINT

A "Complainant" means you or another person, including a Physician or Provider, designated to act on your behalf, who files a Complaint. A "Complaint" means any dissatisfaction expressed by a Complainant orally or in writing to UnitedHealthcare about any aspect of UnitedHealthcare's operation, including, but not limited to: information relied on in making the benefit determination; UnitedHealthcare administration; procedures related to review or appeal of an Adverse Determination; the denial, reduction, or termination of a service for reasons not related to medical appropriateness; the way a service is provided.

It does not mean a misunderstanding or problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to your satisfaction. A Complaint also does not include a Provider's or Member's oral or written expression of dissatisfaction or disagreement with an Adverse Determination, which is defined under How to Appeal an Adverse Determination (Section 11.4).

Within five business days of receiving a Complaint, UnitedHealthcare will send Complainant a letter acknowledging the date of receipt, along with a description of UnitedHealthcare's Complaint process and timeframes. If the Complaint was oral, UnitedHealthcare will also enclose a one-page Complaint form clearly stating that the form must be completed and returned to UnitedHealthcare for prompt resolution of the Complaint.

Within 30 calendar days after UnitedHealthcare receives the written Complaint or Complaint form, UnitedHealthcare will investigate and resolve the Complaint and send Complainant a letter explaining UnitedHealthcare's resolution. The letter will include: 1) the specific medical and contractual reasons for the decision, including any applicable benefit exclusion, limitation, or medical circumstance; 2) additional information required to adjudicate a claim, if needed; 3) the specialization of any Provider consulted; and 4) a full description of the Complaint appeal process, including deadlines for the appeal process and for the final decision on the appeal.

If you dispute the resolution of the Complaint, you may follow UnitedHealthcare's Complaint appeals process described under How to Appeal a UnitedHealthcare Complaint Decision.

Complaints concerning emergencies or denial of continued hospital stays will be investigated and resolved in accordance with the medical or dental immediacy of the case, but no later than one business day from UnitedHealthcare's receipt of the Complaint.

11.3 HOW TO APPEAL A COMPLAINT DECISION

If the Complaint is not resolved to your satisfaction, UnitedHealthcare Complaint appeal process gives you the right to file a written appeal. UnitedHealthcare will send Complainant an acknowledgment letter no later than five business days after the date UnitedHealthcare receives the written request for appeal, and will complete the appeals process no later than 30 calendar days after receiving the written request for appeal.

Complainant or designee will receive a written decision of the Complaint appeal, including the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

Complaint appeals relating to an ongoing emergency or denial of continued hospitalization will be investigated and resolved in accordance with the medical or dental immediacy of the case, but no later than one business day from UnitedHealthcare's receipt of the Complainant's request for an appeal.

At the request of Complainant, UnitedHealthcare will provide a review by a Physician or Provider who has not previously reviewed the case and is of the same or similar specialty that typically manages the medical or dental condition, procedure, or Treatment under consideration in the appeal. The Physician or Provider reviewing the appeal may interview the patient or patient's designated representative and will decide the appeal. The Physician or Provider may deliver initial notice of the appeal decision orally if he or she then provides written notice no later than the third day after the date of the decision.

Upon request and free of charge, Complainant or designee may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim or appeal, including: information relied on to make the decision; information submitted, considered, or generated in the course of making the decision, whether or not it was relied on to make the decision; descriptions of the administrative process and safeguards used to make the decision; records of any independent reviews conducted by UnitedHealthcare; medical judgments, including whether a particular service is Experimental, Investigational, or Unproven or not Medically Appropriate; and expert advice and consultation obtained by UnitedHealthcare in connection with the denied claim, whether or not the advice was relied on to make the decision.

11.4 HOW TO APPEAL AN ADVERSE DETERMINATION

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.

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care Appeals in writing. This communication should include:

1. the patient's name and ID number as shown on the ID card;
2. the Provider's name;
3. the date of medical service;
4. the reason you disagree with the denial; and
5. any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare – Appeals
P.O. Box 740816,
Atlanta, Georgia 30374

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.

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 UnitedHealthcare within 60 days from

receipt of the first level appeal determination. UnitedHealthcare 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.

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. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. UnitedHealthcare's decision will be final.

An "Adverse Determination" means a determination by UnitedHealthcare or a utilization review agent that the health care services provided or proposed to be provided to you are not Medically Appropriate. In life-threatening circumstances, you are entitled to an immediate appeal to an Independent Review Organization ("IRO") and are not required to first comply with UnitedHealthcare's appeal of an Adverse Determination process. An IRO is an organization independent of UnitedHealthcare which may perform a final administrative review of an Adverse Determination made by UnitedHealthcare.

UnitedHealthcare maintains an internal appeal system that provides reasonable procedures for notification, review, and resolution of an oral or written appeal concerning dissatisfaction or disagreement with an Adverse Determination. You, a person acting on your behalf, or your Provider of record must initiate an appeal of an Adverse Determination (which is not part of the Complaint process).

When you, a person acting on your behalf, or your Provider of record expresses orally or in writing any dissatisfaction or disagreement with an Adverse Determination, UnitedHealthcare or a utilization review agent will treat that expression as an appeal of an Adverse Determination.

Within five business days after UnitedHealthcare receives an appeal of Adverse Determination, UnitedHealthcare will send to the appealing party a letter acknowledging the date UnitedHealthcare received the appeal and a list of documents the appealing party must submit. If the appeal was oral, UnitedHealthcare will enclose a one-page appeal form clearly stating that the form must be returned to UnitedHealthcare for prompt resolution. UnitedHealthcare has 30 calendar days from receipt of a written appeal of Adverse Determination or the appeal form to complete the appeal process and provide written notice of the appeal decision to the appealing party. The appeal will be reviewed by a Health Care Provider not involved in the initial decision, who is in the same or similar specialty that typically manages the medical or dental condition, procedure, or Treatment under review.

Notice of UnitedHealthcare's final decision on the appeal will include the dental, medical, and contractual reasons for the resolution; clinical basis for the decision and the specialization of Provider consulted. A denial will also include notice of your right to have an IRO review the denial and the procedures to obtain a review.

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

1. Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, Glossary;
2. 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
3. Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The time frames which you and UnitedHealthcare are required to follow are provided below.

1. Urgent Care Request for Benefits*
    a. If your request for Benefits is incomplete, UnitedHealthcare must notify you within: 24 hours.
    b. You must then provide completed request for Benefits to UnitedHealthcare within: 48 hours after receiving notice of additional information required.
    c. UnitedHealthcare must notify you of the benefit determination within: 24 hours.
    d. If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than: 180 days after receiving the adverse benefit determination.
    e. UnitedHealthcare must notify you of the appeal decision within: 72 hours after receiving the appeal*.

*You do not need to submit Urgent Care Appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

2. Pre-Service Request for Benefits
    a. If your request for Benefits is filed improperly, UnitedHealthcare must notify you within: 5 days.
    b. If your request for Benefits is incomplete, UnitedHealthcare must notify you within: 15 days.
    c. You must then provide completed request for Benefits information to UnitedHealthcare within: 45 days.
    d. UnitedHealthcare must notify you of the benefit determination: if the initial request for Benefits is complete, within: 15 days.
    e. after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within: 15 days.
    f. You must appeal an adverse benefit determination no later than: 180 days after receiving the adverse benefit determination.
    g. UnitedHealthcare must notify you of the first level appeal decision within: 15 days after receiving the first level appeal.
    h. You must appeal the first level appeal (file a second level appeal) within: 60 days after receiving the first level appeal decision.
    i. UnitedHealthcare 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.

3. Post-Service Claims
    a. If your claim is incomplete, UnitedHealthcare must notify you within: 30 days
    b. You must then provide completed claim information to UnitedHealthcare within: 45 days

c. UnitedHealthcare must notify you of the benefit determination: if the initial claim is complete, within: 30 days

d. after receiving the completed claim (if the initial claim is incomplete), within: 30 days

e. You must appeal an adverse benefit determination no later than: 180 days after receiving the adverse benefit determination

f. UnitedHealthcare must notify you of the first level appeal decision within: 30 days after receiving the first level appeal

g. You must appeal the first level appeal (file a second level appeal) within: 60 days after receiving the first level appeal decision

h. UnitedHealthcare 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.

11.5 EXPEDITED APPEAL OF ADVERSE DETERMINATION (EMERGENCIES OR CONTINUED HOSPITALIZATION SITUATIONS)

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. 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.

Appeals relating to ongoing emergencies or denials of continued hospital stays are referred directly to an expedited appeal process for investigation and resolution. They will be concluded in accordance with the medical or dental immediacy of the case but in no event will exceed one working day from the date all information necessary to complete the appeal is received. Initial notice of the decision may be delivered orally if followed by written notice of the decision within three days.

The appeal will be reviewed by a Health Care Provider not involved in the initial decision, which is in the same or similar specialty that typically manages the medical or dental condition, procedure, or Treatment under review. The Physician or Provider reviewing the appeal may interview the patient or patient's designated representative.

11.6 EXTERNAL REVIEW PROGRAM

If the Plan Administrator makes a final determination to deny Benefits, and the Covered Person has exhausted the appeal procedures as described above, the Covered Person may choose to participate in the voluntary External Review Program. This program only applies if the decision is based on either of the following:

1. Clinical reasons.
2. The exclusion for Experimental/Investigational or Unproven Services.
3. Rescission of coverage (coverage that was cancelled or discontinued retroactively).

4. As otherwise required by applicable law.

The voluntary External Review Program is not available if the coverage determinations are based on Benefit exclusions or defined Benefit limits.

This External Review Program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if UnitedHealthcare fails to respond to your appeal within the time lines stated below.

You may request an independent review of the adverse benefit determination. Neither you nor UnitedHealthcare will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. You, your treating Physician or an authorized designated representative may request an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The Independent Review Organization (IRO) has been contracted by UnitedHealthcare and has no material affiliation or interest with UnitedHealthcare or the City. UnitedHealthcare will choose the IRO based on a rotating list of appropriately accredited IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UnitedHealthcare's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

1. all relevant medical records;
2. all other documents relied upon by UnitedHealthcare in making a decision on the case; and
3. all other information or evidence that you or your Physician has already submitted to UnitedHealthcare.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and UnitedHealthcare will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and UnitedHealthcare with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

Section 12
Plan Administration Information

12.1 PLAN NAME AND TYPE OF ADMINISTRATION

The UnitedHealthcare Choice Plus Consumer Driven Health Plan with HSA for City of Austin Employees.

12.2 AGENT FOR SERVICE OF LEGAL PROCESS

UnitedHealthcare
185 Asylum Street
Hartford, CT 06103-3408
(800) 430-7316

12.3 PLAN ADMINISTRATOR

UnitedHealthcare
185 Asylum Street
Hartford, CT 06103-3408
(800) 430-7316

12.4 PLAN SPONSOR

City of Austin
Human Resources Department
505 Barton Springs Road, Suite 600
P.O. Box 1088
Austin, TX 78767-1088
(512) 974-3284

12.5 PRESCRIPTION BENEFIT MANAGER

UnitedHealthcare (OptumRX)
185 Asylum Street
Hartford, CT 06103-3408
(800) 430-7316

12.6 WORKERS' COMPENSATION

This Plan is not in lieu of, and does not affect, any requirement for coverage by workers' compensation.

12.7 PLAN ADMINISTRATION

Each person or entity with respect to the Plan will have only those powers, duties, responsibilities, and obligations as are specifically given under this Plan, either directly or by way of delegation. The Plan Administrator will have sole responsibility for the claims management and administration of the Plan.

12.8 BOOKS AND RECORDS

The City or the Plan Administrator will maintain records which show at all times the names of all eligible Employees, their covered Dependents, if any, the date each Employee became covered under the Plan, and all other information as may be required to administer the Plan and to prepare all notices and reports as the law may require.

12.9 CONFORMITY WITH GOVERNING LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

12.10 EMPLOYEE RETIREMENT INCOME SECURITY ACT NOT APPLICABLE

As a governmental plan, the UnitedHealthcare Choice Plus Plan for City of Austin Employees is exempt from the Employee Retirement Income Security Act (ERISA) of 1974.

12.11 LEGAL ACTIONS

No action at law or in equity shall be brought under this Plan prior to the expiration of 60 days after the claim appeal procedures set forth in this Plan have been exhausted. No such action shall be brought after the expiration of one year after the time the claim appeal procedures have been exhausted. Venue for any lawsuit brought concerning this Plan is Travis County, Texas.

12.12 PATIENT PROTECTION AND AFFORDABLE CARE ACT

As part of the Patient Protection and Affordable Care Act (Health Reform) effective January 2018, medical plans which exceed a threshold level established by the Federal government will have to pay a 40% excise tax. The City of Austin is committed to designing a medical plan that is below the threshold level, however if the threshold is reached the cost of the excise tax will be passed on to Employees and retirees.

Section 13
Definitions

13.1 ACQUIRED BRAIN INJURY

A neurological insult to the brain, which is not hereditary, congenital, or degenerative. The Injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

13.2 ACUPUNCTURIST

A person who is licensed to practice acupuncture by the Texas State Board of Acupuncture Examiners in conjunction with the Texas State Board of Medical Examiners or the equivalent agency of the state where services are performed.

13.3 AFFILIATED EMPLOYER

An entity that the City notifies the Claims Administrator, in writing, is associated with the City. An Affiliated Employer's Employees and former Employees are Covered Persons under the Plan on the effective date in such written notice.

13.4 ALLOWABLE AMOUNT

The maximum amount determined by UnitedHealthcare to be eligible for consideration of payment for a particular service, supply, or procedure. For In-Network Providers, the Allowable Amount is based on the provisions of the In-Network Provider contract and the payment methodology in effect on the date of service, whether Diagnostic Related Grouping (DRG), capitation, relative value, fee schedule, per diem, or other. For Providers that are not In-Network Providers, the Allowable Amount will be based on the applicable UnitedHealthcare regional or state fee schedules or rate and payment methodologies.

13.5 AUTISM SPECTRUM DISORDER

A Neurobiological Disorder that includes Autism, Asperger's syndrome, or pervasive developmental disorder-not otherwise specified. "Neurobiological Disorder" means an Illness of the nervous system caused by genetic, metabolic, or other biological factors.

13.6 CALENDAR YEAR

The period beginning January 1, as of 12:01a.m., of any year and ending December 31, of the same year.

13.7 CARE COORDINATION

Care Coordination program focuses on offering education, accelerating access to care, and providing surveillance and monitoring of chronic conditions. These services include the review of Covered Persons' diagnosis and proposed health care Treatments with respect to whether or not the service is appropriate to treat the condition. The services are designed to facilitate Covered Person education, identify and prevent delays in Treatments, and provide or offer assistance with respect to Covered Persons' health care needs. These services include, but are not limited to those that are highly likely to drive utilization and medical expenses of the Plan. The Plan Administrator will review health care services and supplies to determine whether they are covered services under the Plan. If the Plan Administrator determines that services or supplies are not covered under the Plan, then the Plan Administrator will provide the appeal services as outlined in the Plan.

13.8 CDHP

UnitedHealthcare Consumer Driven Health Plan.

13.9 CHEMICAL DEPENDENCY

The abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

13.10 CHEMICAL DEPENDENCY TREATMENT CENTER

A facility that provides a program for the Treatment of Chemical Dependency pursuant to a written Treatment plan approved by UnitedHealthcare or its designated behavioral health administrator. The facility must be: affiliated with a Hospital under a contractual agreement with an established system for patient Referral; accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; licensed, certified, or approved as a Chemical Dependency Treatment program or center by an agency of the state of Texas having legal authority to so license, certify, or approve; or if outside Texas, licensed, certified, or approved as a Chemical Dependency Treatment program or center by the appropriate agency of the state in which it is located having the legal authority to so license, certify, or approve.

13.11 CHIROPRACTOR

A Doctor of Chiropractic legally qualified and licensed as such and acting in accordance with that license.

13.12 CLAIM DETERMINATION PERIOD

Claim Determination Period means a Calendar Year. However, if the Covered Person has not been covered under this Plan for the full Calendar Year, it is that portion of a Calendar Year during which the Covered Person, for whom a claim is made, has been covered under this Plan.

13.13 COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Federal law that requires employers to offer eligible Covered Persons the opportunity to continue medical coverage at their own cost in the case of certain qualifying events.

13.14 COBRA ADMINISTRATOR

CompuSys/Erisa Group, Inc. (Erisa)
13706 Research Blvd., Ste. 308
Austin, TX 78750
(512) 250-9397

13.15 COINSURANCE

The cost sharing of Covered Expenses between a Covered Person and this Plan. Coinsurance is usually expressed as a percentage.

13.16 CONGENITAL ANOMALY

A physical developmental defect that is present at birth and is identified within the first twelve months of birth.

13.17 COVERED EXPENSES

The portion of various expenses as described in Section 4, Covered Services and Benefits, of this document for which Medical Benefits may be payable. Except as specifically provided, Covered Expenses are for the Medically Appropriate services or supplies for the Treatment of Illness or Injury only. Charges for Covered Services that are provided while the Plan is in effect, determined as follows:

For In-Network Benefits Covered Expenses are based on contracted rates with the provider

For Out-of-Network Benefits Covered Expenses are based on:

1. negotiated rates agreed to by the Out-of-Network Provider and either UnitedHealthcare or one of its vendors, affiliates or subcontractors. Or
2. if rates have not been negotiated, then one of the following amounts:
    a. 140 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, or;
    b. When a rate is not published by CMS for the service, the UnitedHealthcare uses an

available gap methodology to determine a rate for the service as follows:

i For services other than Pharmaceutical Products, the UnitedHealthcare uses a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Ingenix. If the Ingenix relative value scale becomes no longer available, a comparable scale will be used. UnitedHealthcare and Ingenix are related companies through common ownership by UnitedHealth Group;

ii For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These

methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource;

c. When a rate is not published by CMS for the service and a gap methodology does not apply to the service, or the Provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, the Covered Expense is based on 50 percent of the Provider's billed charge, except that certain Covered Expenses for mental health and substance use disorder services are based on 80 percent of the billed charge.

UnitedHealthcare updates the CMS published rate data on a regular basis when updated data from CMS becomes available. Theses updates are typically implemented within 30 to 90 days after CMS updates its data. These provisions do not apply if you receive Covered Services from an Out-of-Network Provider in an Emergency. In that case, Covered Expenses are the amounts billed by the Provider, unless UnitedHealthcare negotiates lower rates.

For certain Covered Services, you are required to pay a percentage of Covered Expenses in the form of Coinsurance.

Covered Expenses are subject to UnitredHealthcare's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the UnitedHealthcare.

13.18 COVERED PERSON

Eligible Employee, Retiree, Dependent, or participant with continuation coverage who is covered by the Plan.

13.19 CUSTODIAL CARE

Care comprised of services and supplies, including room and board, and other institutional services or home care, provided to you primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or Injury. Custodial Care is care that is not a necessary part of medical Treatment for recovery, and includes, but is not limited to, helping you walk, bathe, dress, eat, prepare special diets, and take medication.

13.20 DEDUCTIBLE

The amount of Covered Expenses that the Covered Person must pay in each Calendar Year before benefits are paid according to the Plan for any Covered Expenses incurred during the remainder of that Calendar Year.

13.21 DENTIST

The term Dentist means an individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of that license. For the purpose of this definition, a Doctor will be considered to be a Dentist when performing any dental services within the scope of his or her license.

13.22 DEPENDENT

1. The Spouse or a Domestic Partner of an Employee.
2. An Employee's biological children, stepchildren, legally adopted children, children for whom the Employee has obtained court-ordered guardianship or conservatorship, qualified children placed pending adoption, children of a Domestic Partner, and unmarried grandchildren.

a. To be eligible, the child must be under 26 years of age and dependent on the Employee in a regular parent-child relationship (as reasonably determined by the City), be the subject of a Qualified Medical Child Support Order (QMSCO), or the subject of an administrative writ.

b. To be eligible, a grandchild of the Employee or the Employee's Spouse must meet the requirements stated above, and at the time the application for coverage is submitted, the grandchild must be a Dependent of the Employee or Employee's Spouse for Federal income tax purposes. However, coverage for a grandchild will not be terminated solely because the covered child is no longer a Dependent of the Employee for Federal income tax purposes.

3. Any disabled child who meets all of the following requirements will continue to be considered a Dependent even after reaching age 26, as long as he or she remains incapacitated, and dependent on the Employee for principal support and maintenance:

   a. Meets the requirements above.

   b. Written documentation from the Employee verifying an ongoing total disability and if requested, written documentation from a Physician verifying an ongoing total disability.

   c. Is dependent on the Employee for principal support and maintenance.

   A Dependent child who loses eligibility and later becomes disabled is not eligible to be covered. A disabled child who was not covered by the Plan immediately prior to the time he or she would otherwise cease to be a Dependent is not eligible to be covered.

4. Any other Dependent as required by State or Federal law.

Dependents do not include:

1. Individuals on active duty in any branch of military service, unless Coverage is required by law.
2. Individuals residing in a country other than the United States.
3. Parents, grandparents, or other ancestors.

13.23 DESIGNATED FACILITY

A transplant facility identified by UnitedHealthcare and managed by United Resources Network.

13.24 DIETARY AND NUTRITIONAL SERVICES

Education, counseling, or training (including printed material) regarding diet, regulation or management of diet, or the assessment or management of nutrition.

13.25 DOCTOR

A legally qualified and licensed person, who may administer and prescribe drugs, perform surgery, or otherwise practice a healing art, acting in accordance with that license. For the purposes of the Plan, a Doctor includes: Medical Doctors; Dental Surgeons; Chiropractors; Acupuncturists; Podiatrists; Osteopaths; Optometrists; Psychiatrists; Psychologists; Anesthesiologists; and Radiologists when acting within the scope of their certificate, license, or other state regulation, and when performing acts or providing services that would otherwise be considered as benefits under this Plan but only to the extent permitted by law. See definitions of Chiropractor, Osteopath, Podiatrist, Psychiatrist, and Psychologist.

13.26 DOMESTIC PARTNER

The individual who lives in the same household and shares the common resources of life in a close, personal, intimate relationship with a City Employee if, under Texas law, the individual would not be prevented from marrying the Employee on account of age, consanguinity, or prior undissolved marriage to another. A Domestic Partner may be of the same or opposite gender as the Employee. Only one Domestic Partner is eligible for Coverage at any one time.

13.27 DURABLE MEDICAL EQUIPMENT

DME is equipment that meets all of the following requirements: can withstand repeated use; is primarily and customarily used to treat an active Illness or Injury; generally is not useful to a person in the absence of an Illness or Injury; is appropriate for use in the home; can be purchased only with a prescription. An exception to this definition is breast pumps. Breast pumps are considered a Covered Expense under the Plan.

13.28 EMERGENCY CARE

Health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his condition, sickness, or Injury is of such a nature that failure to get immediate medical care could result in: placing the patient's health in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; serious disfigurement; or in the case of a pregnant woman, serious jeopardy to the health of the fetus.

13.29 EMPLOYEE

A person employed by the City, COBRA participant, Surviving Family Member, or an Employee of an Affiliated Employer.

1. Active Employee or Employee of an Affiliated Employer

A person employed by the City in a position described below, any portion of whose income is subject to withholding tax and/or for whom Social Security contributions are made by the City. Independent contractors and any other such person(s) not considered an Employee by the City are not Employees for the purpose of this Plan.

   a. Active Employee (Full-Time), an Employee who is in a regular budgeted position and is scheduled to work at least 30 hours per week for the City.

   b. Active Employee (Part-Time), an Employee who is in a regular budgeted position and is scheduled to work less than 30 hours per week for the City.

   c. Active Employee (Part-Time), a substitute judge who is not in a regular budgeted position and is scheduled to work less than 30 hours per week for the City.

2. COBRA Participant

An active Employee, or Dependent who is enrolled in the Plan as an active Employee, or Dependent and loses coverage due to a qualifying event will become eligible for COBRA coverage. If this person enrolls in COBRA and pays the regularly scheduled premiums, he or she may continue benefits under this Plan in accordance with the COBRA guidelines outlined in this document. Does not apply to Domestic Partner or Children of a Domestic Partner.

3. Surviving Family Member

Dependent of an enrollee who was enrolled, except for Domestic Partner or child of a Domestic Partner, in a City-sponsored medical plan at the time the Employee was killed in the line of duty

while working for the City. The cause of death must be considered compensable under the City's Workers' Compensation program.

13.30 EXPERIMENTAL/INVESTIGATIONAL OR UNPROVEN

The use of any Treatment, procedure, facility, equipment, drug, device, or supply not accepted as Standard Medical Treatment of the condition being treated or any such items requiring federal or other governmental agency approval not granted at the time services were provided. "Approval" by a federal agency means that the Treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. Medical Treatment includes medical, surgical, or dental Treatment. "Standard Medical Treatment" means the services or supplies that are in general use in the medical community in the United States, and have been demonstrated in peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated; are appropriate for the Hospital or In-Network Provider; and the Health Care Professional has had the appropriate training and experience to provide the Treatment or procedure.

UnitedHealthcare shall determine whether any Treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational or Unproven and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a Health Care Professional may have prescribed Treatment, and the services or supplies may have been provided as the Treatment of last resort, such services or supplies still may be considered to be Experimental/Investigational or Unproven within this definition. Treatment provided as part of a Clinical Trial or a research study is Experimental/Investigational or Unproven.

13.31 EXTENDED CARE/SKILLED NURSING FACILITY

A facility licensed by the state in which it is located to provide skilled nursing services and which meets all of the following requirements:

1. Is operated in accordance with the state's laws.
2. Is duly licensed to keep patients regularly overnight.
3. Is supervised by a qualified Doctor or Nurse.
4. Provides 24-hour skilled nursing care by licensed nursing staff under the direction of a full-time registered Nurse.
5. Provides training in self-care for the essential activities of daily living.
6. Maintains a complete medical record on each patient.
7. Has a Utilization Review plan for each patient.
8. Is approved as a participating Skilled Nursing Facility in the Medicare program at the time of the Covered Person's admission.

13.32 FEDERAL LEGEND DRUG

Any medicinal substance which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law prohibits dispensing without prescription," is restricted by the state, and can be dispensed only by a licensed drug dispenser upon written receipt of a prescription.

13.33 FREE STANDING FACILITY

A diagnostic laboratory, or x-ray facility that is not located in a Hospital, in a hospital-affiliated facility or a Doctor's office.

13.34 HEALTH CARE PROFESSIONALS

Physicians, Nurses, audiologists, Physician's assistant, Nurse first assistants, Acupuncturists, clinical Psychologists, pharmacists, occupational therapists, physical therapists, speech and language pathologists, surgical assistants, and other professionals engaged in the delivery of health services who are licensed, practice under an institutional license, or are certified, or practice under authority of a Physician or legally constituted professional association, or other authority consistent with state law.

13.35 HEALTH CARE PROVIDER

A person or institution that is legally qualified and licensed or otherwise authorized to provide health care services when acting within the scope of that license or other state regulation and when performing acts or providing services to the extent permitted by law.

13.36 HIPAA COORDINATOR

City of Austin Human Resources Department HIPAA Coordinator
P.O. Box 1088, Austin, TX 78767
(512) 974-3284

13.37 HIPAA PRIVACY RULE

Health Insurance Portability and Accountability Act Privacy Rule (HIPAA). The portion of the Federal Health Insurance Portability and Accountability Act of 1996 that mandates privacy protection for certain health care information, as set forth in Parts 160 and 164 of Title 45, Code of Federal Regulations.

13.38 HOME HEALTH CARE AGENCY

A home health care agency as defined by Medicare, or an agency which is licensed by the state in which it is located as a home health care agency, or an agency or organization which provides a program of home health care which meets all of the following requirements:

1. It is certified by the patient's Doctor as an appropriate Provider of home health care services.
2. It has a full-time administrator.
3. It maintains a home health care plan for each patient.
4. It maintains written records of services provided to the patient.
5. Its staff includes at least one registered Nurse (R.N.), or nursing care by an R.N. is available.

13.39 HOSPICE

A licensed or certified agency, which is approved by the attending Doctor to provide counseling and incidental medical services and may provide room and board to a Covered Person diagnosed as terminally ill by such Doctor.

13.40 HOSPITAL

Hospital means a public or private institution licensed by the state in which it is located and operated in accordance with that state's laws. The Hospital must provide Inpatient Care and Treatment through medical diagnostic and major surgical facilities on its premises, under the

supervision of a staff of Doctors, and with 24-hour-a-day nursing service. The term also includes parts of Hospital institutions used mainly as facilities for Treatment of Chemical Dependency.

The term does not include nursing homes or institutions or parts of institutions used mainly as facilities for convalescence, nursing, or for rest of the elderly.

Hospital also means, where appropriate in context, rehabilitation Hospital, which means any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of Doctors with permanent facilities equipped and operated solely for the purpose of providing Treatment for persons who have experienced an Illness or Injury resulting in a loss of functional abilities.

Hospital means, for the purposes of Chemical Dependency Treatment, a facility which provides a program for the Treatment of Chemical Dependency pursuant to a written Treatment plan approved and monitored by a Doctor and which facility meets any of the following requirements:

1. Is accredited as such a facility by the Joint Commission of Accreditation of Hospitals.
2. Is affiliated with a Hospital, under a contractual agreement with an established system for patient referral.
3. Is licensed as a Chemical Dependency Treatment program by the Texas Commission on Alcohol and Drug Abuse, or the equivalent agency of another state, if any.
4. Is licensed, certified, or approved as a Chemical Dependency Treatment program or center by any other state agency having legal authority to so license, certify, or approve.

13.41 ILLNESS

Sickness or disease that requires Treatment by a Health Care Provider.

13.42 INCURRED DATE

The date on which a medical service or supply is received, provided, or obtained.

13.43 INFERTILITY

The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual sexual intercourse. This does not include conditions for male Members when the cause is a vasectomy or orchiectomy or for female Members when the cause is a tubal ligation or hysterectomy.

13.44 INJURY

A bodily Injury resulting from a traumatic event or extreme exposure to the elements that requires Treatment by a Health Care Provider.

13.45 IN-NETWORK

A network of Doctors, Health Care Providers, Pharmacies, and Facilities contracted with UnitedHealthcare to provide services to Covered Persons.

13.46 INPATIENT ADMISSION

A continuous stay in a Hospital, Extended Care/Skilled Nursing Facility, or combination thereof, due to an Illness or Injury diagnosed by a Doctor.

13.47 INPATIENT CARE

Hospital room and board and general nursing care for a person confined in a Hospital as an inpatient for at least 24 consecutive hours.

13.48 INPATIENT REHABILITATION FACILITY

A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (Physical Therapy, Occupational Therapy and/or Speech Therapy) on an inpatient basis, as authorized by law.

13.49 LICENSED PROFESSIONAL COUNSELOR

A person licensed by the Texas State Board of Examiners of Professional Counselors.

13.50 MAINTENANCE PRESCRIPTION DRUGS

Doctor-prescribed Drugs which ordinarily are used to treat chronic Illness or otherwise associated with continuous therapy for several months or more, and which are designated by the Prescription Benefit Manager as Maintenance Prescription Drugs.

13.51 MARRIAGE AND FAMILY THERAPY

The provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

13.52 MAXIMUM ALLOWABLE CHARGE

The Maximum Allowable Charge for a Medically Appropriate service or supply is the maximum benefit payable, as determined by the Plan Administrator.

For Services provided by an In-Network Provider, Maximum Allowable Expenses are Based On: Contracted rates with the Provider.

For Services Provided by an Out-of-Network Provider, Maximum Allowable Expenses are Based On:

1. negotiated rates agreed to by the Out-of-Network Provider and either UnitedHealthcare or one of its vendors, affiliates or subcontractors, at the discretion of UnitedHealthcare.
2. if rates have not been negotiated, then one of the following amounts:
    a. 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, or
    b. When a rate is not published by CMS for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
        1) For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by *Ingenix, Inc*. If the *Ingenix, Inc*. relative value scale becomes no longer available, a comparable scale will be used. UnitedHealthcare and *Ingenix, Inc.* are related companies through common ownership by UnitedHealth Group.
        2) For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals.

These methodologies are currently created by RJ Health Systems, Thompson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

c. When a rate is not published by CMS for the service and a gap methodology does not apply to the service, or the Provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, the Maximum Allowable Expenses is based on 50% of the Provider's billed charge, except that certain Maximum Allowable Expenses' for mental health and substance use disorder services are based on 80% of the billed charge.

d. for Mental Health Services and Substance Use Disorder Services the Maximum Allowable Expenses will be reduced by 25% for Covered Health Services provided by a Psychologist and by 35% for Covered Services provided by a masters level counselor.

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

These provisions do not apply if you receive Covered Services from an Out-of-Network Provider in an Emergency. In that case, Maximum Allowable Expenses are the amounts billed by the Provider, unless UnitedHealthcare negotiates lower rates.

13.53 MEDICAL BENEFITS

The benefits described in Section 4, Covered Services and Benefits.

13.54 MEDICAL DIRECTOR

A Physician of UnitedHealthcare, or designee, who is responsible for monitoring the provision of Covered Services to Members.

13.55 MEDICAL SOCIAL SERVICES

Those social services relating to the Treatment of a Member's medical condition. Such services include, but are not limited to assessment of the social and emotional factors related to the Member's Illness, need for care, response to Treatment, and adjustment to care; and the relationship of the Member's medical and nursing requirements to the home situation, financial resources, and available community resources.

13.56 MEDICALLY APPROPRIATE

Services or supplies (except as limited or excluded herein) that are: essential to, consistent with, and provided for the diagnosis or the direct care and Treatment of the condition, sickness, disease, Injury, or bodily malfunction; provided in accordance with and consistent with generally accepted standards of medical practice in the United States; not primarily for your convenience, or the convenience of your In-Network Provider; the most economical supplies or levels of service appropriate for your safe and effective Treatment; and are not considered Experimental/Investigational or Unproven.

When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered or your condition, and you cannot receive safe or adequate care as an outpatient. In determining whether a service is Medically Appropriate, UnitedHealthcare may consider the views of the state and national medical communities and the guidelines and practices of Medicare, Medicaid, or other government-financed programs and peer reviewed literature. Although an In-Network Provider may have prescribed Treatment, such Treatment may not be Medically Appropriate within this definition. This definition applies only

to UnitedHealthcare's determination of whether health care services are Covered Services under this Plan.

13.57 MEDICARE

Title XVIII of the Social Security Act and all amendments thereto.

13.58 MENTAL HEALTH CARE

Any one or more of the following:

1. The diagnosis or Treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, or any other diagnostic coding system as used by UnitedHealthcare or its designated behavioral health administrator, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin.
2. The diagnosis or Treatment of any symptom, condition, disease, or disorder by an In-Network Provider when the Covered Service is: individual, group, family, or conjoint psychotherapy, counseling, psychoanalysis, psychological testing and assessment, the administration or monitoring of psychotropic drugs, or Hospital visits (if applicable) or consultations in a facility listed in item 5, below.
3. Electroconvulsive Treatment.
4. Psychotropic drugs.
5. Any of the services listed in items 1 - 4, above, performed in or by a Hospital (if applicable), or other licensed facility or unit providing such care.

13.59 MENTAL HEALTH TREATMENT FACILITY

A facility that: meets licensing standards; mainly provides a program for diagnosis, evaluation, and Treatment of acute mental or nervous disorders; prepares and maintains a written plan of Treatment for each patient based on medical, psychological, and social needs; provides all normal infirmary level medical services or arranges with a Hospital for any other medical services that may be required; is under the supervision of a Psychiatrist; and provides skilled nursing care by licensed Nurses who are directed by a registered Nurse.

13.60 MIDWIFE

A person who is certified, registered, and/or licensed as a Midwife by the state in which that person is practicing to assist in childbirth.

13.61 NON-RESIDENT

A Covered Person who is determined by the City of Austin and UnitedHealthcare to live outside a UnitedHealthcare Service Area.

13.62 NURSE

A registered graduate Nurse (R.N.), licensed practical Nurse (L.P.N.), or licensed vocational Nurse (L.V.N.) who is licensed under the laws of the state in which he or she resides or is registered by an organization operated with the approval of the medical profession.

13.63 OCCUPATIONAL THERAPY

Doctor-prescribed Treatment provided by a licensed occupational therapist acting in accordance with that license.

13.64 OPEN ENROLLMENT

The period of time designated by the City during which eligible Employees are allowed to make coverage changes for the next Plan Year.

13.65 OSTEOPATH

A Doctor of Osteopathy legally qualified and licensed as such and acting in accordance with that license.

13.66 OTHER PLAN

The following plans providing benefits or services for medical or dental care or Treatment:

1. Group insurance or any other arrangement for coverage of individuals in a group whether on an insured basis or uninsured basis.
2. Any other prepayment coverage, including Medicare.
3. No-fault automobile coverage. For purposes of this Plan, in states with compulsory no-fault automobile insurance laws, each individual shall be deemed to have full no-fault coverage to the maximum available in that state. This Plan will coordinate benefits with no-fault coverage as defined in the state of residence, whether or not the individual is in compliance with the law or whether or not the maximum coverage is carried.

13.67 OUT-OF-AREA

Not within the Service Area.

13.68 OUT-OF-NETWORK

Doctors, Health Care Providers, Pharmacies, and Facilities who have not contracted with the Plan Administrator to provide services.

13.69 OUT-OF-POCKET

The portion of Covered Expenses that a Covered Person must pay, in the form of Deductible(s) and Coinsurance, before the Plan pays 100% of Covered Expenses for the remainder of that Calendar Year.

13.70 OUTPATIENT CARE

Services, supplies, and medicines provided and used under the direction of a Doctor to a person for who Room and Board Charges are not incurred.

13.71 OUTPATIENT SURGICAL FACILITY

Any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of Doctors with permanent facilities that are equipped and operated solely for the purpose of performing Surgical Procedures and with continuous Doctor services and registered professional nursing services whenever a patient is in the facility and which does not provide services or other accommodations for patients to stay overnight. An Outpatient Surgical Facility can be located within a Hospital or as a freestanding surgical facility.

13.72 IN-NETWORK PHARMACY

A pharmacy within the UnitedHealthcare network of pharmacies.

13.73 IN-NETWORK PROVIDER

A Health Care Provider who has contracted with UnitedHealthcare to provide services to Covered Persons.

13.74 PHYSICAL THERAPY

Doctor-prescribed Treatment provided by a licensed physical therapist acting in accordance with that license.

13.75 PHYSICIAN

A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is properly licensed or certified to provide medical care (within the scope of the license) under the laws of the state where the individual practices.

13.76 PLAN

The UnitedHealthcare Choice Plus CDH with HSA Plan for City of Austin Employees, as set forth in this document, and as amended.

13.77 PLAN ADMINISTRATOR

The organization contracting with the City of Austin to administer the self-funded medical plan.

13.78 PLAN YEAR

A period of 12 consecutive months, beginning January 1, and ending December 31.

13.79 PODIATRIST

A Doctor of Podiatry legally qualified and licensed as such and acting in accordance with that license.

13.80 POST-DELIVERY CARE

Postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments, including parent education, assistance and training in breast and bottle feeding, and the performance of necessary and appropriate clinical tests.

13.81 PRE-NOTIFICATION

Notification by Providers or patients for designated services prior to the provision of services. This applies to inpatient Hospital admissions including Mental Health and Chemical Dependency, Skilled Nursing Facility admissions, Home Health Care, Hospice services, and the rental or purchase of Durable Medical Equipment that cost more than $1,000.

For In-Network facilities, your Provider is responsible for notifying Care Coordination.

For Out-of-Network facilities, you are responsible for notifying Care Coordination. Failure to follow this requirement will result in a reduction in the level of Plan-paid benefits to 50% of the Maximum Allowable Charges for all related Covered Services. The additional Coinsurance will not apply toward the Out-of-Pocket Maximum.

This program requires Pre-Notification to the Plan Administrator for all Inpatient Admissions as follows:

1. For elective Inpatient Admission, except for childbirth: At least five business days before admission.
2. For Inpatient Admission for childbirth: As soon as the expected delivery date is known, and again within two business days following the actual admission.
3. Emergency Hospital Admissions: At least two business days, or as soon as reasonably possible following the admission.

4. Urgent Hospital Admissions: At least two business days prior to admission.

Failure to follow these requirements will result in a reduction in the level of Plan-paid benefits to 50% for all related Covered Expenses. The additional Coinsurance will not apply toward the Out-of-Pocket Maximum.

13.82 PRESCRIPTION BENEFIT MANAGER

A vendor contracted by UnitedHealthcare (OptumRX) which has special expertise in managing network pharmaceutical programs and in administering network pharmacy dispensing programs, and will serve as the manager of pharmaceutical services to Covered Persons.

13.83 PRESCRIPTION DRUG CARD

A card issued to a Covered Person to be used at an In-Network Pharmacy to purchase drugs for your Coinsurance. This may or may not be the same as the medical ID card issued by the Plan Administrator.

13.84 PREVAILING MEDICAL STANDARDS AND CLINICAL GUIDELINES

The nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

13.85 PRIMARY CARE PHYSICIAN (PCP)

Physician who specializes in family practice, internal medicine, obstetrics/gynecology, or pediatrics.

13.86 PRIOR PLAN

A City-sponsored self-funded plan of Medical Benefits.

13.87 PROFESSIONAL SERVICES

Those Medically Appropriate Covered Services rendered by Physicians and other Health Care Professionals in accordance with this Plan.

13.88 PROSTHETIC APPLIANCES

Artificial devices including limbs or eyes, braces, or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ, Dental appliances and the replacement of cataract lenses are not considered Prosthetic Appliances.

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.

13.89 PROTECTED HEALTH INFORMATION (PHI)

Individually identifiable health information, including demographic information collected from a Covered Person, transmitted or maintained in any form or medium, that relates to the past, present, or future physical or mental condition of a Covered Person, the provision of health care to a Covered Person, or the payment for the provision of health care to a Covered Person.

13.90 PROVIDER

Any duly licensed institution, Physician, Health Care Professional, or other entity which is licensed to provide health care services.

13.91 PSYCHIATRIC DAY TREATMENT FACILITY

An institution that is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Serious Mental Illness services to Members for periods of time not to exceed eight hours in any 24-hour period. Any Treatment in such facility must be certified in writing by the attending Physician to be in lieu of hospitalization.

13.92 PSYCHIATRIST

A Doctor certified by the American Board of Psychiatry and Neurology who is recognized by the law of the state in which Treatment is received as qualified to treat the type of Illness or Injury causing the expenses being claimed, has spent at least three years in psychiatric residency, and specializes in the diagnosis, Treatment, and prevention of mental Illness and emotional problems.

13.93 PSYCHOLOGIST

A Doctor engaged in the discipline and study of human behavior, who is duly licensed or certified in the state where the service is provided and has a doctoral degree in psychology and has had at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology.

13.94 RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL ABNORMALITIES

Surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

13.95 RESIDENTIAL TREATMENT

A program that provides 24-hour services for patients who are having difficulty functioning in social, family, school, or self-care situations. Residential Treatment primarily provides a safe, structured environment with a medically supervised behavior management program. Residential Treatment is not primarily for acute care or crisis stabilization.

13.96 RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND ADOLESCENTS

A childcare institution that provides residential care and Treatment for emotionally disturbed children and adolescents and that is accredited as a Residential Treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Health Care Organizations, or the American Association of Psychiatric Services for Children.

13.97 ROOM AND BOARD CHARGES

All charges commonly made by a Hospital on its own behalf for a bed, linen service, meals (including special diets and nourishments), and for all general services and activities essential to the care of registered inpatients.

13.98 SEMI-PRIVATE ROOM

A room in a Hospital or Extended Care/Skilled Nursing Facility containing two or more beds for other than intensive care.

13.99 SERVICE AREA

The geographical area served by UnitedHealthcare.

13.100 SCIENTIFIC EVIDENCE

The results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.

13.101 SKILLED NURSING FACILITY

An institution or distinct part of an institution that is licensed or approved under state or local law, and primarily provides skilled nursing care and related services as a Skilled Nursing Facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Healthcare Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by UnitedHealthcare to meet the reasonable standards applied by either of those authorities.

13.102 SOCIAL WORKER

A person with a Master of Social Work (M.S.W.) degree or a Certified Social Worker (C.S.W.) degree who is licensed and/or certified by the state in which the person is practicing.

13.103 SPECIALIST

A duly licensed Provider, other than a PCP.

13.104 SPEECH THERAPY

Doctor-prescribed Treatment provided by a licensed speech pathologist acting in accordance with that license.

13.105 SPOUSE

The person to whom the Employee is married, and whose marriage has been licensed, solemnized, and registered in accordance with the statutory law of the jurisdiction in which the marriage occurred. However, regardless of where it occurred, the marriage must be recognized in the State of Texas. For purposes of this Plan, a Spouse in an informal (common-law) marriage in a state that recognizes common-law marriage is considered an eligible Dependent on submission of the appropriate documentation. Only one Spouse is eligible for Coverage at any one time.

13.106 SURGICAL PROCEDURE

A Surgical Procedure is any operative or diagnostic procedure performed in the Treatment of an Illness or Injury by instrument or cutting procedure through any natural body opening or incision.

13.107 SURVIVING FAMILY MEMBER

Spouse or Child of an enrollee who was enrolled in a City-sponsored medical plan at the time the Employee was killed in the line of duty while working for the City. The cause of death must be considered compensable under the City's Workers' Compensation program.

13.108 THERAPEUTIC SERVICES

Includes chemotherapy, intravenous infusion therapy, and dialysis.

13.109 TREATMENT

Medically Appropriate care and Surgical Procedures appropriate for the Illness or Injury.

13.110 URGENT CARE APPEAL

Those appealed claims that require notification or approval prior to receiving medical care, where a delay in Treatment could seriously jeopardize the Covered Person's life, health, or ability to regain maximum function, or in the opinion of a Physician with knowledge of the Covered Person's medical condition, could cause severe pain.

13.111 VISION CARE

A routine eye examination performed by a Doctor for the purpose of prescribing glasses or contact lenses.

Section 14
Health Savings Account (HSA)

What this attachment includes:

- About Health Savings Accounts.
- Who is eligible and how to enroll.
- Contributions.
- Additional medical expense coverage available with your Health Savings Account.
- Using the HSA for Non-Qualified Expenses.
- Rolling over funds in your HSA.

14.1 INTRODUCTION

This attachment to the Summary Plan Description (SPD) describes some key features of the Health Savings Account (HSA) that you could establish to complement the Consumer Driven Health Plan, which is a high deductible medical plan. In particular, and except as otherwise indicated, this attachment will address the Health Savings Account, and not the high deductible health plan that is associated with the "HSA".

City of Austin has entered into an agreement with United Healthcare Services, Inc., Minnetonka, MN, and ("UnitedHealthcare") under which UnitedHealthcare will provide certain administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this attachment. Further, note that it is the Plan's intention to comply with *Department of Labor* guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.

The HSA described in this section is not an arrangement that is established and maintained by City of Austin. Rather, the HSA is established and maintained by the HSA trustee, OptumBank. However, for administrative convenience, a description of the HSA is provided in this section.

14.2 ABOUT HEALTH SAVINGS ACCOUNTS

You gain choice and control over your health care decisions and expenditures when you establish your HSA to complement the high deductible medical plan described in the SPD.

An HSA is an account funded by you, your employer, or any other person on your behalf. The HSA can help you to cover, on a tax free basis, medical plan expenses that require you to pay out-of-pocket, such as Deductibles or Coinsurance. It may even be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay non-medical expenses, however, these amounts are subject to income tax and may be subject to 20% penalty.

You have three tools you can use to meet your health care needs:

- Consumer Driven Health Plan, a high deductible medical plan which is discussed in your Summary Plan Description.
- An HSA you establish.
- Health information, tools, and support.

Benefits available under your medical plan are described in your medical plan Summary Plan Description (SPD).

What is an HSA?
An HSA is a tax-advantaged account Participants can use to pay for qualified health expenses they or their eligible dependents incur. HSA contributions:

- Accumulate over time with interest or investment earnings.
- Are portable after employment.
- Can be used to pay for qualified health expenses tax-free.

14.3 WHO IS ELIGIBLE AND HOW TO ENROLL

Eligibility to participate in the Health Savings Account is described below. You must be covered under a high deductible medical plan in order to participate in the HSA. In addition, you:

- Must not be covered by any high deductible medical plan considered non-qualified by the IRS. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS.)
- Must not participate in a full health care Flexible Spending Account (FSA).
- Must not be entitled to Benefits under Medicare (i.e., enrolled in Medicare).
- Must not be claimed as a dependent on another person's tax return.

14.4 CONTRIBUTIONS

Contributions to your HSA can be made by you, by your employer or by any other individual. All funds placed into your HSA are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee.

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the contributions reach the contribution maximum.

Note that if coverage under a qualified high deductible health plan terminates, no further contributions may be made to the HSA.

The contribution maximum is the single and family limits set by federal regulations. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds to their HSA up to the maximum allowed by federal regulations. The maximum limits set by federal regulations may be found on the IRS website at www.irs.gov.

If you enroll in your HSA within the year (not on January 1) you will still be allowed to contribute the maximum amount set by federal regulations. However, you must remain enrolled in a high deductible health plan and HSA until the end of the 12th month from your initial enrollment or you will be subject to tax implications and an additional tax of 10%.

Note: Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15th of the following year.

14.5 Reimbursable Expenses

The funds in your HSA will be available to help you pay your or your eligible dependents' out-of-pocket costs under the medical plan, including Annual Deductibles and Coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses". Please see the description of *Additional Medical Expense Coverage Available With Your Health Savings Account* below, for additional information. HSA funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include the medical expenses of you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

HSA funds may also be used to pay for non-qualified health expenses, including health expenses for non-IRS Dependents, but will generally be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

14.6 Additional Medical Expense Coverage Available with Your Health Savings Account

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional medical services and you have funds in your HSA, you may use the funds in your HSA to pay for the medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not Covered Health Services, you will still be required to pay the provider for services.

The monies paid for these additional medical expenses will not count toward your Annual Deductible or Out-of-Pocket Maximum.

14.7 Rollover Feature

If you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will roll-over. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the accompanying high deductible health plan, as described in your medical plan SPD.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

Important
Be sure to keep your receipts and medical records that verify you paid for qualified expenses using your HSA. If you are ever audited by the IRS, you may be asked to provide these receipts or records. If you did not use your HSA to pay for qualified health expenses, you may need to report the distribution as taxable income on your tax return. City of Austin and UnitedHealthcare will not verify that distributions from your HSA are for qualified health expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. City of Austin and the Plan Administrator are not responsible or liable for the misuse by Participants of HSA funds by, or for the use by Participants of HSA funds for non-qualified health expenses.

14.8 Additional Information About the HSA

It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, UnitedHealthcare and/or the financial institution holding your HSA funds, Optum Bank may provide the health care professional with information regarding the balance in your HSA. At no time will UnitedHealthcare provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this information disclosed, you must notify the Plan Administrator and Optum Bank in writing.

For more information, contact Optum Bank at (800) 791-9361.

You can obtain additional information on your HSA online at www.irs.gov. You may also contact your tax advisor. Please note that additional rules may apply to a Dependent's intent to opening an HSA.