KyPSC Staff First Set Data Requests
Duke Energy Kentucky
Case No. 2006-00172
Date Received: May 17, 2006
Response Due Date: June 14, 2006

KyPSC-DR-01-021

REQUEST:

21. Provide complete details of Duke Kentucky's Other Post-retirement Employee Benefits package(s) provided to electric employees.

RESPONSE:

See Attachment KyPSC-DR-01-021 for the most recent Summary Plan Description of the medical and dental plans available to retirees.

WITNESS RESPONSIBLE: C. James O'Connor

SCI DOC ID 480603
RIGHT HAND PAGE

Summary Plan Description

United HealthCare Low PPO Plan

for

Cinergy Corp.

Group Number: 239203

Effective Date: January 1, 2004

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Introduction

We are pleased to provide you with this Summary Plan Description (SPD). This SPD describes your Benefits, as well as your rights and responsibilities, under the Plan.

How to Use this Document

We encourage you to read your SPD and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitation of this SPD by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions). You should also carefully read (Section 9: General Legal Provisions) to better understand how this SPD and your Benefits work. You should call the Claims Administrator if you have questions about the limits of the coverage available to you.

Many of the sections of the SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. We encourage you to keep your SPD and any attachments for your future reference.

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

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Information about Defined Terms

Because this SPD is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 10: Glossary of Defined Terms). You can refer to Section 10 as you read this document to have a clearer understanding of your SPD.

When we use the words "we," "us," and "our" in this document, we are referring to the Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in (Section 10: Glossary of Defined Terms).

Your Contribution to the Benefit Costs

The Plan may require the Participant to contribute to the cost of coverage. Contact your Benefits representative for information about any part of this cost you may be responsible for paying.

Customer Service and Claims Submittal

Please make note of the following information that contains Claims Administrator department names and telephone numbers.

Customer Service Representative (questions regarding Coverage or procedures): As shown on your ID card.

Care Coordination℠/Notification: As shown on your ID card.

Mental Health/Substance Abuse Services Designee: As shown on your ID card.

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Claims Submittal Address:

United HealthCare Insurance Company

PO Box 740800

Atlanta, GA 30374-0800

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Insurance Company

PO Box 740816

Atlanta, GA 30374-0816

Internet:

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

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).
- Covered Health Services that require you to notify Care Coordination℠ before you receive them.

Accessing Benefits

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits you must see a Network Physician or other Network provider.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive. For details about when Network Benefits apply, see (Section 3: Description of Network and Non-Network Benefits).

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

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

Copayment

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment, see (Section 10: Glossary of Defined Terms). Copayment amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Copayments are calculated as a percentage (rather than as a set dollar amount) the percentage is based on Eligible Expenses.

Eligible Expenses

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

We have delegated to the Claims Administrator the discretion and authority to initially determine on our behalf whether a treatment or

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supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

For Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills, unless you agreed to reimburse the provider for such services. For non-Network Benefits, except for fees that are negotiated by a non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

Notification Requirements

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

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

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

- Accidental Dental Services.
- Durable Medical Equipment over $1,000.
- Home Health Care.
- Hospice Care.
- Hospital Confinements.

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- Maternity Care that exceeds 48 hours for normal delivery and 96 hours for Caesarian birth.
- Inpatient Mental Health and Substance Abuse Services.
- Reconstructive Procedures.
- Skilled Nursing/Inpatient Rehabilitation Facility Confinement.
- Transplant Services.
- Breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature.

To notify Care Coordination℠ or the Mental Health/Substance Abuse Designee, call the telephone number on your ID card for Claims Administration.

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

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

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- Any other limitation or exclusion of the Plan.

Special Note Regarding Medicare

If you are enrolled for Medicare on a primary basis (Medicare pays before we pay Benefits under the Plan), the notification requirements described in this SPD do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in (Section 7: Coordination of Benefits). You are not required to notify Care Coordination℠ before receiving Covered Health Services when Medicare is the primary payer.

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Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms).	***Network*** $1,000 per Covered Person per calendar year, not to exceed $2,000 for all Covered Persons in a family.
	Covered Expenses charged by both Network and non-network Providers apply towards both the Network Individual and Family Deductibles and the non-network Individual and Family Deductibles.	***Non-Network*** $2,000 per Covered Person per calendar year, not to exceed $4,000 for all Covered Persons in a family.
Copayment	The charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses.	***Network and Non-Network*** See each Benefit in **Section 1: What's Covered - - Benefits** for further information.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	***Network*** $2,000 per Covered Person per calendar year, not to exceed $4,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.
	Covered Expenses charged by both Network and non-network Providers	***Non-Network*** $4,000 per Covered Person per calendar year, not to exceed $8,000 for all

Payment Term	Description	Amounts
	apply towards both the Network Individual and Family Out-of-Pocket Maximums and the non-network Individual Family Out-of-Pocket Maximums.	Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.
Maximum Plan Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Plan. For a complete definition of Maximum Plan Benefit, see (Section 10: Glossary of Defined Terms).	***Network and Non-Network*** $2,000,000 per Covered Person.

Benefit Information

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services Acupuncture services for pain therapy when both of the following are true: • Another method of pain management has failed. • The service is performed by a provider in the provider's office. Where such Benefits are available, acupuncture is a Covered Health Service for the treatment of: • Nausea of Chemotherapy, or • Post-operative nausea, or • Nausea of early Pregnancy. Any combination of Network and Non-Network Benefits is limited to 20 visits per calendar year.	***Network*** No ***Non-Network*** No	$25 per visit 40%	No Yes	No Yes
2. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	***Network*** No	*Ground Transportation:* 20% *Air Transportation:* 20%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
	Non-Network No	Same as Network	Same as Network	Same as Network
3. Ambulance Services - Non-Emergency Transportation by professional ambulance, other than air ambulance, to and from a medical facility.	***Network*** No	*Ground Transportation:* 20%	Yes	Yes
Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment.		*Air Transportation:* 20%		
Note: Except in life threatening circumstances, notification for Air Ambulance transport is required	***Non-Network*** No	20%	Yes	Yes
4. Christian Science Practitioner Covered Health Services rendered when:	***Network*** Not Covered	Not Covered	Not Covered	Not Covered
• The frequency is reasonable and comparable to treatment by another health care provider.				
• The Christian Science Nurse or Practitioner is listed in the Christian Science Journal at the time the charge is made.	***Non-Network*** No	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
5. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 48 hours of the accident. Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be both of the following: • Started within three months of the accident. • Completed within 12 months of the accident. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to	***Network*** Yes	*Office Visit:* $25	No	No
		Alternate Setting: 20%	Yes	Yes
	Non-Network Yes	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
teeth that are injured as a result of such activities. **Notify Care Coordination℠** Please remember that you should notify Care Coordination℠ as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.) When you provide notification, Care Coordination℠ can verify that the service is a Covered Health Service.				
6. Diagnostic and Therapeutic Services Covered Health Services received on an outpatient basis including: • Lab and radiology/X-ray. • Mammography testing. • Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy). A standard test (such as a Mammogram, PSA or Pap Smear) associated with an annual preventative screening will be covered at 100%. If additional follow-up testing is required, the standard Copayment will apply. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	***Network*** No	20%	Yes	Yes
	Non-Network No	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
7. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment. Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen concentrator units and the rental of equipment to administer oxygen. • Delivery pumps for tube feedings. • Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service, including necessary adjustments to shoes to accommodate braces. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions.	***Network*** Yes, for items more than $1,000. ***Non-Network*** Yes, for items more than $1,000.	20% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Diabetic pump. We provide Benefits for a single unit of Durable Medical Equipment (example one insulin pump) and provide repair for that unit. Benefits are provided for the replacement of a type of Durable Medical Equipment once every three calendar years. Care Coordination℠ will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor Care Coordination℠ identifies. **Notify Care Coordination℠** Please remember that you must notify Care Coordination℠ before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item). If you don't notify Care Coordination℠, Benefits for Durable Medical Equipment will be subject to a $300 penalty.				
8. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits).	***Network*** Yes, but only for an Inpatient Stay.	$75 per visit	No	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
The $75 Emergency Health Services Copayment is waived if the Covered Person is admitted to a Hospital. Additionally, no Benefits are provided if the service is deemed to be non-Emergency in nature. **Notify Care Coordination℠** To ensure prompt and accurate payment of your claim as a Network Benefit, notify Care Coordination℠ within two business days or as soon as possible after you receive outpatient Emergency Health Services at a non-Network Hospital or Alternate Facility. Please remember that if you are admitted to a Hospital as a result of an Emergency, you must notify Care Coordination℠ within two business days or the same day of admission, or as soon as reasonably possible. If you don't notify Care Coordination℠, Benefits for the Hospital Inpatient Stay will be subject to a $300 penalty. Benefits will not be reduced for the outpatient Emergency Health Services.	***Non-Network*** Yes, but only for an Inpatient Stay.	Same as Network	Same as Network	Same as Network
9. Home Health Care Services received from a Home Health Agency that are both of the following: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home.	***Network*** Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required. Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician. • It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair. • It requires clinical training in order to be delivered safely and effectively. • It is not Custodial Care. Care Coordination℠ will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Any combination of Network and Non-Network Benefits is limited to 40 visits per calendar year. One visit equals four hours of skilled care services.	***Non-Network*** Yes	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify Care Coordination℠ Please remember that you should notify Care Coordination℠ five business days before receiving services. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.				
10. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency.	***Network*** Yes	20%	Yes	Yes
Notify Care Coordination℠ Please remember that you must notify Care Coordination℠ five business days before receiving services. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.	***Non-Network*** Yes	40%	Yes	Yes
11. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds).	***Network*** Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify Care Coordination℠ Please remember that you must notify Care Coordination℠ as follows: • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. • For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.	***Non-Network*** Yes	40%	Yes	Yes
12. Infertility Services Covered Health Services for the diagnosis and treatment of the underlying medical condition causing infertility when provided by or under the direction of a Physician.	***Network*** No	20%	Yes	Yes
	Non-Network No	40%	Yes	Yes
13. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	***Network*** No	*Office Visit:* $25 per visit	No	No
		Injection Only: 20%	Yes	Yes

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

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If you don't notify Care Coordination℠ that the Inpatient Stay will be extended, your Benefits for the extended stay will be subject to a $300 penalty.				
15. Mental Health and Substance Abuse Services - Outpatient Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy). • Crisis intervention. • Psychological testing.	***Network*** No	20%	Yes	Yes
Any combination of Network and Non-Network Benefits for Mental Health Services and/or Substance Abuse Services is limited to 50 visits per calendar year.	***Non-Network*** No	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16. Mental Health and Substance Abuse Services - Inpatient and Intermediate Mental Health Services and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being. The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. Network Benefits for Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services and Substance Abuse Services. Any combination of Network and Non-Network Benefits for Mental Health Services and/or Substance Abuse Services is limited to 30 days per calendar year.	***Network*** You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	20%	Yes	Yes
	Non-Network You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Authorization Required Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number appears on your ID card. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.				
17. Nutritional Counseling Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include: • Diabetes mellitus. • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias. Benefits are limited to three individual sessions during a Covered Person's lifetime for each medical condition.	***Network*** No ***Non-Network*** No	20% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
18. Outpatient Surgery Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including surgery and related services. Network and Non-Network Benefits for radiology, anesthesiology and pathology are 20%.	***Network*** No	20%	Yes	Yes
Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services* below. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	***Non-Network*** No	40%	Yes	Yes
19. Physician's Office Services Covered Health Services received in a Physician's office including: • Treatment of a Sickness or Injury. • Preventive medical care. • Voluntary family planning. • Well-baby and well-child care. • Routine well woman examinations, including pap smears, pelvic examinations and mammograms. • Routine well man examinations, including PSA examinations.	***Network*** No	$25 per visit No Copayment applies when no Physician charge is assessed.	No	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Routine physical examinations, including vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment or the fitting or purchase of eyeglasses or contact lenses.) • Immunizations.				
Network Benefits for immunizations where there is no Physician charge assessed are 20%.	***Non-Network*** No	40% No Benefits for preventive care.	Yes	Yes
20. Private Duty Nursing Covered Health Services for private duty nursing care given on an outpatient basis when provided by a licensed nurse (R.N., L.P.N., or L.V.N.).	***Network*** No	20%	Yes	Yes
Benefits are limited to a maximum of $5,000 per Covered Person per calendar year.	***Non-Network*** No	40%	Yes	Yes
21. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.	***Network*** No	20%	Yes	Yes

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

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

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
provided in the same manner and at the same level as those for any Covered Health Service. You can contact Care Coordination℠ at the telephone number on your ID card for more information about Benefits for mastectomy-related services. **Notify Care Coordination℠** Please remember that you should notify Care Coordination℠ five business days before receiving services. When you provide notification, Care Coordination℠ can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage.				
24. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy. • Occupational therapy. • Speech therapy. • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your	***Network*** No ***Non-Network*** No	*Office Visit:* $25 *Alternate Setting:* 20% 40%	No Yes Yes	No Yes Yes

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

condition within two months of the start of treatment. Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.

Speech Therapy for Children under Age Three

Services of a licensed speech therapist for treatment given to a child under age three whose speech is impaired due to one of the following conditions:

- Infantile autism.
- Development delay or cerebral palsy.
- Hearing impairment.

Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Any combination of Network and Non-Network Benefits is limited as follows:

- 20 visits of physical therapy per calendar year.
- 20 visits of occupational therapy per calendar year.
- 20 visits of speech therapy per calendar year.

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
25. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Any combination of Network and Non-Network Benefits is limited to 120 days per calendar year. Please note that, in general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting. The Covered Person is expected to improve to a predictable level of recovery. Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are required intermittently (such as physical therapy three times a week). Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is	***Network*** Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence. (Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)				
Notify Care Coordination℠ Please remember that you must notify Care Coordination℠ as follows: • For elective admissions: five business days before admission. • For non-elective admission: within one business day or the same day of admission. • For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.	***Non-Network*** Yes	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
26. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Network or non-Network Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day. Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Any combination of Network and Non-Network Benefits for Spinal Treatment is limited to 20 visits per calendar year.	***Network*** No ***Non-Network*** No	$25 40%	No Yes	No Yes
27. Temporomandibular Joint Dysfunction (TMJ) Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident,	***Network*** No	Office Visit: $25 Alternate Setting: 20%	No Yes	No Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
trauma, congenial defect, developmental defect, or orpathology. Please note that Benefits are not available for charges of services that are Dental in nature. A combination of Network and Non-Network Benefits is limited to a maximum of $1,500 per Covered Person per lifetime for non-surgical services and supplies relating to TMJ.	***Non-Network*** No	40%	Yes	Yes
28. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Physician. For the highest level of Benefits, transplantation services must be received at a Designated United Resource Network Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational Service or an Unproven Service. Care Coordination℠ notification is required for all transplant services. The services described under **Transportation and Lodging** below are Covered Health Services **ONLY** in connection with a transplant received at a Designated United Resource Network Facility. • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone	***Network*** Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated United Resource Network Facility. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of $25,000 is payable for all charges made in connection with the search. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants. • Liver transplants. • Liver/small bowel transplants. • Pancreas transplants. • Small bowel transplants.				
Benefits for cornea transplants that are provided by a Physician at a Network Hospital are paid as if the transplant was received at a Designated United Resource Network Facility. We do not require that cornea transplants be performed at a Designated United Resource Network Facility in order for you to receive the highest level of Network Benefits. Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by Care Coordination to be a proven procedure for the involved	***Non-Network*** Yes	40%	Yes	Yes

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

diagnoses.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact Care Coordination℠ at the telephone number on your ID card for information about these guidelines.

Transportation and Lodging

Care Coordination℠ will assist the patient and family with travel and lodging arrangements only when services are received from a Designated United Resource Network Facility. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

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

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures. **Notify Care Coordination℠** You must notify Care Coordination℠ as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.				
29. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.	***Network*** No	20%	Yes	Yes
	Non-Network No	40%	Yes	Yes

Section 2: What's Not Covered--Exclusions

This section contains information about:

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

How We Use Headings in this Section

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

Plan Exclusions

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

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

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

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

A. Alternative Treatments

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

B. Comfort or Convenience

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

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

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

C. Dental

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

D. Drugs

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

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4. Over the counter drugs and treatments.

E. Experimental or Investigational Services or Unproven Services

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

F. Foot Care

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

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.

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

H. Mental Health/Substance Abuse

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

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

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

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any services, treatments, items or supplies provided for in (Section 1: Covered Health Services) may be covered.

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

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Except as described in (Section 1: What's Covered -- Benefits) under *Nutritional Counseling,* nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms.) Examples include:
   - — Pharmacological regimens, nutritional procedures or treatments.
   - — Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - — Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

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4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental Injury in excess of one per lifetime, up to a maximum of $500.

K. Providers

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

   This exclusion does not apply to mammography testing.

L. Infertility/Reproduction

1. Surrogate parenting.
2. The reversal of voluntary sterilization.

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3. Fees or direct payment to a donor for sperm or ovum donations.
4. Fees relating to Assisted Reproductive Technology. (Such as Artificial Insemination, Invitro Fertilization, GIFT & ZIFT)
5. Monthly fees for maintenance and/or storage of frozen embryos.
6. Health services associated with an elective abortion or the use of non-surgical or drug-induced Pregnancy termination.
7. Contraceptive supplies and services.
8. Fetal reduction surgery.
9. Health services associated with the use of non-surgical or drug-induced Pregnancy termination.

M. Services Provided under Another Plan

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

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

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

N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer.
5. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in (Section 1: What's Covered--Benefits), unless determined by Care Coordination to be a proven procedure for the involved diagnoses.

O. Travel

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

P. Vision and Hearing

1. Purchase cost of eye glasses, contact lenses, or hearing aids.
2. Fitting charge for hearing aids, eye glasses or contact lenses.
3. Eye exercise therapy.
4. Routine vision examinations.

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

5. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. All Other Exclusions

1. *Health services and supplies that do not meet the definition of a* Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - — Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - — Related to judicial or administrative proceedings or orders.
   - — Conducted for purposes of medical research.
   - — Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.

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8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature, including oral appliances.
9. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment *except as* a treatment of temporomandibular joint or sleep apnea.
11. Non-surgical treatment of obesity, including morbid obesity.
12. Surgical treatment of obesity including severe morbid obesity (with a BMI greater than 35).
13. Growth hormone therapy.
14. Sex transformation operations.
15. Custodial Care.
16. Domiciliary care.
17. Private duty nursing received on an inpatient basis.
18. Respite care.
19. Rest cures.
20. Psychosurgery.
21. Treatment of benign gynecomastia (abnormal breast enlargement in males).
22. Medical and surgical treatment of excessive sweating (hyperhidrosis).
23. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
24. Appliances for snoring.

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

25. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
26. Any charges relating to a Physician visit that was performed in the Covered Person's home.
27. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
28. Any charge for services, supplies or equipment advertised by the provider as free.
29. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
30. Any charges prohibited by federal anti-kickback or self-referral statutes.
31. Any additional charges submitted after payment has been made and your account balance is zero.
32. Any outpatient facility charge in excess of payable amounts under Medicare.
33. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
34. Outpatient rehabilitation services, Spinal Treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
35. Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies.
36. Speech therapy to treat stuttering, stammering, or other articulation disorders.
37. Liposuction.

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38. Chelation therapy, except to treat heavy metal poisoning.
39. Personal trainer.
40. Naturalist.

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Section 3: Description of Network and Non-Network Benefits

This section includes information about:

- Network Benefits.
- Non-Network Benefits.
- Your responsibility for notification.
- Emergency Health Services.

Network Benefits

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

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

Please note that Mental Health and Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee.

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Please see (Section 1: What's Covered--Benefits) under the heading for *Mental Health and Substance Abuse.*

Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	A higher level of Benefits means less cost to you. See (Section 1: What's Covered--Benefits).	A lower level of Benefits means more cost to you. See (Section 1: What's Covered--Benefits).
Who Should Notify Care Coordination℠	You must notify Care Coordination℠ for certain Covered Health Services. Failure to notify results in reduced Benefits or no Benefits. See (Section 1: What's Covered--Benefits), under the *Must You Notify Care Coordination℠?* column.	You must notify Care Coordination℠ for certain Covered Health Services. Failure to notify results in reduced Benefits or no Benefits. See (Section 1: What's Covered--Benefits), under the *Must You Notify Care Coordination℠?* column.
Who Should File Claims	Not required. We pay Network providers directly.	You must file claims. See (Section 5: How to File a Claim).

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	Network	Non-Network
Outpatient Emergency Health Services	Emergency Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means that if you seek Emergency care at a non-Network facility, you are not required to meet the Annual Deductible or to pay any difference between Eligible Expenses and the amount the provider bills.	

Provider Network

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

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

Separately, you will automatically be given a directory of Network providers at no cost to you. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You are responsible for verifying a provider's Network status prior to receiving services, even when you are referred by another Network provider. You can verify the provider's status by calling the Claims Administrator.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

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

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

Designated United Resource Network Facilities and Other Providers

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

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

Non-Network Benefits

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by non-Network Physicians or non-Network providers. Non-Network Benefits are also payable for Covered Health Services that are provided at non-Network facilities. If there is no Network Provider within a 30 mile radius of your home zip code or no Network Specialist within a 50 mile radius of your home zip code, you may be eligible to receive benefits for certain Covered Health Services paid at the Network level. You may check a provider's status in your area by visiting www.myuhc.com or by calling Customer Service at the number on the back of your ID

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card. All benefits that fall under this category must be approved prior to receipt of care and are subject to any plan limitations or exclusions set forth in this SPD.

Your Responsibility for Notification

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

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

Care Coordination[SM]

When you notify Care Coordination[SM] as described above, they will work with you to implement the Care Coordination[SM] process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

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

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

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Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person must complete an online enrollment through YBR (Your Benefits Resources) website or by calling the iPeople Center within 31 days of eligibility or during Annual Enrollment. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

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

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

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

If You Are Eligible for Medicare

You will be responsible for the costs that Medicare would have paid if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

If you are enrolled in a Medicare+Choice (Medicare Part C) plan, you will be responsible for any additional costs or reduced benefits that result if you fail to follow the requirements of the Medicare+Choice plan. Please see *Medicare Eligibility* in (Section 9: General Legal Provisions) for more information about how Medicare may affect your Benefits.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	Eligible Person usually refers to an Employee or Retiree who meets the eligibility rules of this Plan. When an Eligible Person actually enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person and Participant, see (Section 10: Glossary of Defined Terms). If both spouses are Eligible Persons of the Plan Sponsor, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both. Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll without our written permission.	Cinergy Corp. determines who is eligible to enroll under the Plan.
Dependent	Dependent generally refers to the Participant's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms). Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent.	Cinergy Corp. determines who qualifies as a Dependent.

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date of hire or qualified status change if you complete an online enrollment through YBR (Your Benefits Resource) or by calling the iPeople Center within 31 days of the date the Eligible Person becomes eligible to enroll.
Open Enrollment Period	Eligible Persons may enroll themselves and their Dependents.	Cinergy Corp. determines the Open Enrollment Period. Coverage begins on the 1st day of the following calendar year.
New Eligible Persons	New Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date of the qualified status change if you enroll through the YBR (Your Benefit Resource) website or by calling the iPeople Center within 31 days of the event.
Adding New Dependents	Participants may enroll Dependents who join their family because of any of the following events: • Birth. • Legal adoption. • Placement for adoption. • Marriage. • Legal guardianship. • Court or administrative order.	Coverage begins on the date of the qualified status change if you enroll through the YBR (Your Benefit Resource) website or by calling the iPeople Center within 31 days of the event.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because required contributions were not paid on a timely basis.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

A special enrollment period applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - — Loss of eligibility (including, without limitation, legal separation, divorce or death).
  - — The employer stopped paying the contributions.
  - — In the case of COBRA continuation coverage, the coverage ended.

Event Takes Place (for example, a birth or marriage). Coverage begins on the date of the event if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the event.

Missed Initial Enrollment Period or Open Enrollment Period. Coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

Section 5: How to File a Claim

This section provides you with information about:

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

If You Receive Covered Health Services from a Network Provider

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

Filing a Claim for Benefits

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us through the Claims Administrator. You must file the claim in a format that contains all of the information required, as described below.

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

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

Required Information

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

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

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

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- Provider of service Name, Address and Tax Identification Number

E. The date the Injury or Sickness began.

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

Payment of Benefits

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

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

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

Benefit Determinations

Post-Service Claims

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

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

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

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

Pre-Service Claims

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

Urgent Claims that Require Immediate Action

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment

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could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

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

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

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

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

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

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Concurrent Care Claims

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

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

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Section 6: Questions and Appeals

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

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

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

What to Do First

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

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

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

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

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

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

Appeal Process

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

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

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

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

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

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

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

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from us as the Plan Administrator. Your second level appeal request must be submitted to us in writing within 60 days from receipt of the first level appeal decision.

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

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

Urgent Claim Appeals that Require Immediate Action

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

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

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

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Section 7: Coordination of Benefits

This section provides you with information about:

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

Benefits When You Have Coverage under More than One Plan

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

When Coordination of Benefits Applies

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

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

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Order of Benefit Determination Rules

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

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

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

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

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

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

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the Coverage Plan covering the person as an Employee, Retiree or Dependent is secondary and the other Coverage Plan is primary.

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

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

1) The parents are married;

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

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

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

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

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

1) The Coverage Plan of the custodial parent;

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

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

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

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a Dependent of a person covered as a Retiree or an Employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a Dependent of an actively working spouse will be determined under the rule labeled D(1).
4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an Employee or Retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored.
5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an Employee or Retiree longer is primary.
6. If a husband or wife is covered under this Coverage Plan as a Participant and as an Enrolled Dependent, the Dependent Benefits will be coordinated as if they were provided under another Coverage Plan, this means the Participant's benefit will pay first.
7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

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Effect on the Benefits of this Plan

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

1. Determine its obligation to pay or provide Benefits under its contract;
2. Determine whether a benefit reserve has been recorded for the Covered Person; and
3. Determine whether there are any unpaid Allowable Expenses during that claim determination period.

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

B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, Benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.
C. This Coverage Plan reduces its Benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

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Medicare Benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled for Medicare. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare Benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

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

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

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Coverage Plan. We will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means reasonable cash value of the Benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the Benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

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Section 8: When Coverage Ends

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

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

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

General Information about When Coverage Ends

We may discontinue this Benefit Plan and/or all similar benefit Plans at any time, as permitted or required by law.

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

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

With the exception of a surviving spouse of the Participant, an Enrolled Dependent's coverage ends on the date the Participant's coverage ends or sooner if the Participant chooses to end the Dependent's coverage or as otherwise set forth in this SPD.

In some cases, you may have the right and option to choose to continue coverage at your expense, even though you may no longer qualify as an Employee, Retiree or Dependent. For more information on this issue, see this section's discussion of Continuation of coverage under federal law (COBRA).

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

Events Ending Your Coverage

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

Ending Event	What Happens
The Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms "Eligible Person", "Participant", "Dependent" and "Enrolled Dependent."
The Claims Administrator Receives Notice to End Coverage	Your coverage ends on the last day of the calendar month in which the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
Participant Retires or Is Pensioned	The coverage that you have as an Employee may be available to you in retirement. The Cinergy iPeople Center can provide you with this information as well as explain how to elect coverage as a retiree.

Other Events Ending Your Coverage

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

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

Coverage for a Handicapped Child

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

- Is not able to be self-supporting because of mental retardation or physical handicap.
- Depends mainly on the Participant for support.

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

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

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

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

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

For purposes of the Plan, a person who meets the definition of a Handicapped Child, as just explained, shall be considered a Dependent for coverage purposes.

Continuation of Coverage

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

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

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

Continuation Coverage under Federal Law (COBRA)

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

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

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

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

Qualifying Events for Continuation Coverage under COBRA

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

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

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Notification Requirements and Election Period for Continuation Coverage under COBRA

The Participant or other Qualified Beneficiary must notify the Plan Administrator within 60 days of the Participant's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Participant or other Qualified Beneficiary fails to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Participant is continuing coverage under federal law, the Participant must notify the Plan Administrator within 60 days of the birth or adoption of a child.

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

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

COBRA Terminating Events

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

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

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

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

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

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

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E. The date, after electing continuation coverage, that coverage is first obtained under any other group health Plan.

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

G. The date the entire Plan ends.

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

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

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

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Section 9: General Legal Provisions

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

Plan Document

This document is the Plan document and the Summary Plan Description.

Relationship with Providers

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

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

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

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

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

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

Your Relationship with Providers

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

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

Incentives to Providers

The Claims Administrator pays Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

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Examples of financial incentives for Network providers are:

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

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

Incentives to You

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

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Interpretation of Benefits

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

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

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

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

Administrative Services

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

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Amendments to the Plan

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

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

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

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. The terms of this Plan may not be amended by oral statements made by the Plan Sponsor, the Plan Administrative Committee, the Claims Administrator, or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

Information and Records

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

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

We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers

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may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we or the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan Administrator.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

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

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

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If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in (Section 7: Coordination of Benefits), we will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare+Choice (Medicare Part C) Plan on a primary basis (Medicare pays before Benefits under the Plan), you **should** follow all rules of that Plan that require you to seek services from that Plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare+Choice Plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, the Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits the Plan provided to Covered Persons, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Summary Plan Description, the Plan shall

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also have an independent right to be reimbursed by Covered Persons for the reasonable value of any services and Benefits the Plan provides to Covered Persons, from any or all of the following listed below.

- Third parties, including any person alleged to have caused a Covered Person to suffer injuries or damages.
- Any person or entity who is or may be obligated to provide Benefits or payments to a Covered Person, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to a Covered Person on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties".

Covered Persons agree as follows:

- That a Covered Person will cooperate with the Plan in a timely manner in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by the Plan,
  - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - appearing at depositions and in court, and
  - obtaining the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and/or the institution of legal action against a Covered Person.
- That the Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a Covered Person to pursue his or her damage/personal injury claim.
- That regardless of whether a Covered Person have been fully compensated or made whole, the Plan may collect from Covered Persons the proceeds of any full or partial recovery that a Covered Person or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection shall include, but not be limited to any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by the Plan may also be considered to be benefits advanced.

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- That Covered Persons agree that if they receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, the Covered Person will serve as a constructive trustee over the funds and failure to hold such funds in trust will be deemed as a breach of the Covered Persons duties hereunder.

- That Covered Persons or an authorized agent, such as the Covered Person's attorney, must hold any funds received from any potentially responsible party that are due and owed to the Plan, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the institution of legal action against the Covered Person.

- That the Plan shall be entitled to recover reasonable attorney fees from Covered Persons incurred in collecting from the Covered Person any funds held by the Covered Person that he or she recovered from any Third Party.

- That the Plan may set off from any future benefits otherwise allowed by the Plan the value of benefits paid or advanced under this section to the extent not recovered by the Plan.

- That Covered Persons will neither accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval, nor will the Covered Person do anything to prejudice the Plan's rights under this section.

- That Covered Persons will assign to the Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits the Plan provided, plus reasonable costs of collection.

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- That the Plan's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom Covered Persons are seeking recovery, to be paid before any other of the Covered Person's claims are paid.

- That the Plan's rights will not be reduced due to the Covered Person's own negligence.

- That the Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the Covered Persons name, which does not obligate the Plan in any way to pay the Covered Person part of any recovery the Plan might obtain.

- That the Plan shall not be obligated in any way to pursue this right independently or on behalf of the Covered Person.

- That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.

- That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan beneficiary, this section applies to the personal representative of the deceased Plan beneficiary.

Refund of Overpayments

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

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.

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- All or some of the payment we made exceeded the Benefits under the Plan.

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

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

Limitation of Action

You cannot bring any legal action against us or the Claim Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in (Section 5: How to File a Claim) and all required reviews of your claim have been completed. If you want to bring a legal action against us or the Claims Administrator you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us or the Claims Administrator.

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

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Section 10: Glossary of Defined Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not

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

Covered--Exclusions), including Experimental or Investigational Services and Unproven Services.

Covered Health Services must be provided:

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

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

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

Custodial Care - services that:

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

Dependent - the Participant's legal spouse or an unmarried Dependent child of the Participant or the Participant's spouse,

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

including a surviving spouse, if such spouse remains unmarried from the time of the Employee's or Retiree's death. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A Handicapped Child, as described in (Section 8: When Coverage Ends).
- A child for whom legal guardianship has been awarded to the Participant or the Participant's spouse.

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

- A Dependent includes any unmarried Dependent child under 19 years of age.
- A Dependent includes an unmarried Dependent child who is 19 years of age or older, but less than 25 years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - — The child must not be regularly employed on a full-time basis.
  - — The child must be a Full-time Student.
  - — The child must be primarily Dependent upon the Participant for support and maintenance.

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

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

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

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

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

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

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

Eligible Expenses are based on either of the following:

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

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers, unless you receive services as a result of an Emergency, Eligible Expenses are determined at the Claims Administrator's discretion by either (1) calculating Eligible Expenses based on available data resources of competitive fees in that geographic area, or (2) applying the negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors.

Eligible Expenses are determined solely in accordance with the Claim Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claim Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

Eligible Person - a regular full-time Employee of the Plan Sponsor who is scheduled to work at his or her job at least 20 hours per week or otherwise considered by the Plan Sponsor to be an Employee for

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

Plan coverage purposes; or a person who retires while covered under the Plan.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

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

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

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

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

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.

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- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

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

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

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, beautician school automotive school or similar training school.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case,

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

the provider will be a Network provider for the Health Services and products included in the participation agreement, and a non-Network provider for other Health Services and products. The participation status of providers will change from time to time.

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

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

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

Out-of-Pocket Maximum - the maximum amount you pay out-of-pocket every calendar year after the Annual Deductible is met. If you use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Depending on the geographic area and the service you receive, you may have access to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, your Coinsurance for Non-Network Benefits will remain the same, however the total amount that you owe may be less than if you received services from other non-Network providers because the Eligible Expenses may be a lesser amount.

Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year.

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

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

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

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

- Any charges for non-Covered Health Services.
- The amount of any reduced Benefits if you don't notify Care Coordination℠ as described in (Section 1: What's Covered--Benefits) under the *Must You Notify Care Coordination℠?* column.
- Charges that exceed Eligible Expenses.

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

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

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

Plan - United HealthCare Low PPO Plan for Cinergy Corp. Health Benefit Plan.

Plan Administrator - is the Cinergy Corp. or its designee as that term is defined under ERISA.

Plan Sponsor - Cinergy Corp.. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Pregnancy - includes all of the following:

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

Retiree - any person who retires from Cinergy and is determined and approved by the Plan Sponsor to be eligible to receive coverage under the Plan as a Retiree.

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

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

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

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

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

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

Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

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

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

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- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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

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

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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RIGHT HAND PAGE

Riders, Amendments, Notices

Attachment I

Attachment II

Attachment I

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

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

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

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

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

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Attachment II

Summary Plan Description

Name of Plan: Cinergy Corp. Health & Welfare Benefits Plan, as it relates to the United HealthCare Low PPO Plan for Cinergy Corp; Group Number 239203

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

Cinergy Corp.
139 East Fourth Street
Cincinnati, OH 45202
(513) 287-3333

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

Employer Identification Number (EIN): 31-1385023

IRS Plan Number: 506

Effective Date of Plan: January 1, 2004

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Type of Plan: Self-insured health and welfare benefits plan, offering group health plan benefits to Employees, Retirees and their Dependents

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

Cinergy Corp.
139 East Fourth Street
Cincinnati, OH 45202
(513) 287-3333

Claims Administrator: The following entity provides certain administrative services for the Plan.

United HealthCare Insurance Company
450 Columbus Blvd.
Hartford, CT 06115-0450

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

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Person designated as agent for service of legal process: Service of process may also be made upon the Plan Administrator.

Source of contributions under the Plan: There are no contributions to the Plan. All Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required Participant contributions are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

Method of calculating the amount of contribution: Participant-required contributions to the Plan Sponsor are the Participant's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required Participant contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to Participants.

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

Determinations of Qualified Medical Child Support Orders.

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

Although the Plan Sponsor currently intends to continue the Benefits provided by this Plan, the Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add Benefits or terminate this Plan or this Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or Amendment to or termination

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

of the Plan, its Benefits or its terms and condition, in whole or in part, shall be made solely in a written Amendment (in the case of a change or Amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The Amendment or resolution is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or Amendments to the Plan.

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

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

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

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

Receive Information About Your Plan and Benefits

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

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Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another group health Plan. In addition, if your Plan coverage ceases, you have the right to be provided a certificate of creditable coverage, free of charge, from the Plan, as well as any other group health plan or health insurance issuer when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. You should know that, currently, the Plan does not impose any pre-existing condition limitations or exclusions.

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Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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SCI DOC ID 480596
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Summary Plan Description

United HealthCare High PPO Plan

for

Cinergy Corp.

Group Number: 239203

Effective Date: January 1, 2004

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Introduction

We are pleased to provide you with this Summary Plan Description (SPD). This SPD describes your Benefits, as well as your rights and responsibilities, under the Plan.

How to Use this Document

We encourage you to read your SPD and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitation of this SPD by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions). You should also carefully read (Section 9: General Legal Provisions) to better understand how this SPD and your Benefits work. You should call the Claims Administrator if you have questions about the limits of the coverage available to you.

Many of the sections of the SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. We encourage you to keep your SPD and any attachments for your future reference.

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

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Information about Defined Terms

Because this SPD is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 10: Glossary of Defined Terms). You can refer to Section 10 as you read this document to have a clearer understanding of your SPD.

When we use the words "we," "us," and "our" in this document, we are referring to the Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in (Section 10: Glossary of Defined Terms).

Your Contribution to the Benefit Costs

The Plan may require the Participant to contribute to the cost of coverage. Contact your Benefits representative for information about any part of this cost you may be responsible for paying.

Customer Service and Claims Submittal

Please make note of the following information that contains Claims Administrator department names and telephone numbers.

Customer Service Representative (questions regarding Coverage or procedures): As shown on your ID card.

Care Coordination℠/Notification: As shown on your ID card.

Mental Health/Substance Abuse Services Designee: As shown on your ID card.

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Claims Submittal Address:

United HealthCare Insurance Company

PO Box 740800

Atlanta, GA 30374-0800

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Insurance Company

PO Box 740816

Atlanta, GA 30374-0816

Internet:

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

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).
- Covered Health Services that require you to notify Care Coordination℠ before you receive them.

Accessing Benefits

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits you must see a Network Physician or other Network provider.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive. For details about when Network Benefits apply, see (Section 3: Description of Network and Non-Network Benefits).

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

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

Copayment

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment, see (Section 10: Glossary of Defined Terms). Copayment amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Copayments are calculated as a percentage (rather than as a set dollar amount) the percentage is based on Eligible Expenses.

Eligible Expenses

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

We have delegated to the Claims Administrator the discretion and authority to initially determine on our behalf whether a treatment or

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supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

For Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills, unless you agreed to reimburse the provider for such services. For non-Network Benefits, except for fees that are negotiated by a non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

Notification Requirements

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

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

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

- Accidental Dental Services.
- Durable Medical Equipment over $1,000.
- Home Health Care.
- Hospice Care.
- Hospital Confinements.
- Maternity Care that exceeds 48 hours for normal delivery and 96 hours for Caesarian birth.

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- Inpatient Mental Health and Substance Abuse Services.
- Reconstructive Procedures.
- Skilled Nursing/Inpatient Rehabilitation Facility Confinement.
- Transplant Services.
- Breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature.

To notify Care Coordination℠ or the Mental Health/Substance Abuse Designee, call the telephone number on your ID card for Claims Administration.

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

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

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Special Note Regarding Medicare

If you are enrolled for Medicare on a primary basis (Medicare pays before we pay Benefits under the Plan), the notification requirements described in this SPD do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in (Section 7: Coordination of Benefits). You are not required to notify Care Coordination℠ before receiving Covered Health Services when Medicare is the primary payer.

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Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms).	***Network*** $200 per Covered Person per calendar year, not to exceed $400 for all Covered Persons in a family.
	Covered Expenses charged by both Network and non-network Providers apply towards both the Network Individual and Family Deductibles and the non-network Individual and Family Deductibles.	***Non-Network*** $400 per Covered Person per calendar year, not to exceed $800 for all Covered Persons in a family.
Copayment	The charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses.	***Network and Non-Network*** See each Benefit in **Section 1: What's Covered - - Benefits** for further information.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	***Network*** $1,200 per Covered Person per calendar year, not to exceed $2,400 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.

Payment Term	Description	Amounts
Out-of-Pocket Maximum	Covered Expenses charged by both Network and non-network Providers apply towards both the Network Individual and Family Out-of-Pocket Maximums and the non-network Individual Family Out-of-Pocket Maximums.	***Non-Network*** $2,400 per Covered Person per calendar year, not to exceed $4,800 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.
Maximum Plan Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Plan. For a complete definition of Maximum Plan Benefit, see (Section 10: Glossary of Defined Terms).	***Network and Non-Network*** $2,000,000 per Covered Person.

Benefit Information

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services Acupuncture services for pain therapy when both of the following are true: • Another method of pain management has failed. • The service is performed by a provider in the provider's office. Where such Benefits are available, acupuncture is a Covered Health Service for the treatment of: • Nausea of Chemotherapy, or • Post-operative nausea, or • Nausea of early Pregnancy. Any combination of Network and Non-Network Benefits is limited to 20 visits per calendar year.	***Network*** No ***Non-Network*** No	$15 per visit 30%	No Yes	No Yes
2. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	***Network*** No	*Ground Transportation:* 10% *Air Transportation:* 10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
	Non-Network No	Same as Network	Same as Network	Same as Network
3. Ambulance Services - Non-Emergency Transportation by professional ambulance, other than air ambulance, to and from a medical facility. Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment.	***Network*** No	*Ground Transportation:* 10% *Air Transportation:* 10%	Yes	Yes
Note: Except in life threatening circumstances, notification for Air Ambulance transport is required	***Non-Network*** No	10%	Yes	Yes
4. Christian Science Practitioner Covered Health Services rendered when: • The frequency is reasonable and comparable to treatment by another health care provider.	***Network*** Not Covered	Not Covered	Not Covered	Not Covered
• The Christian Science Nurse or Practitioner is listed in the Christian Science Journal at the time the charge is made.	***Non-Network*** No	30%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
5. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 48 hours of the accident. Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be both of the following: • Started within three months of the accident. • Completed within 12 months of the accident. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to	***Network*** Yes	*Office Visit:* $15	No	No
		Alternate Setting: 10%	Yes	Yes
	Non-Network Yes	30%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
teeth that are injured as a result of such activities. **Notify Care Coordination℠** Please remember that you should notify Care Coordination℠ as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.) When you provide notification, Care Coordination℠ can verify that the service is a Covered Health Service.				
6. Diagnostic and Therapeutic Services Covered Health Services received on an outpatient basis including: • Lab and radiology/X-ray. • Mammography testing. • Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy). A standard test (such as a Mammogram, PSA or Pap Smear) associated with an annual preventative screening will be covered at 100%. If additional follow-up testing is required, the standard Copayment will apply. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	***Network*** No ***Non-Network*** No	10% 30%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
7. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment. Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen concentrator units and the rental of equipment to administer oxygen. • Delivery pumps for tube feedings. • Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service, including necessary adjustments to shoes to accommodate braces. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions.	***Network*** Yes, for items more than $1,000.	10%	Yes	Yes
	Non-Network Yes, for items more than $1,000.	30%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Diabetic pumps. We provide Benefits for a single unit of Durable Medical Equipment (example one insulin pump) and provide repair for that unit. Care Coordination℠ will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor Care Coordination℠ identifies. **Notify Care Coordination℠** Please remember that you must notify Care Coordination℠ before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item). If you don't notify Care Coordination℠, Benefits for Durable Medical Equipment will be subject to a $300 penalty.				
8. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits). The $75 Emergency Health Services Copayment is waived if the Covered Person is admitted to a Hospital. Additionally, no Benefits are provided if the service is deemed to be non-Emergency in nature.	***Network*** Yes, but only for an Inpatient Stay. ***Non-Network*** Yes, but only for an Inpatient Stay.	$75 per visit Same as Network	No Same as Network	No Same as Network

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify Care Coordination℠ To ensure prompt and accurate payment of your claim as a Network Benefit, notify Care Coordination℠ within two business days or as soon as possible after you receive outpatient Emergency Health Services at a non-Network Hospital or Alternate Facility. Please remember that if you are admitted to a Hospital as a result of an Emergency, you must notify Care Coordination℠ within two business days or the same day of admission, or as soon as reasonably possible. If you don't notify Care Coordination℠, Benefits for the Hospital Inpatient Stay will be subject to a $300 penalty. Benefits will not be reduced for the outpatient Emergency Health Services.				
9. Home Health Care Services received from a Home Health Agency that are both of the following: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required. Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:	***Network*** Yes ***Non-Network*** Yes	10% 30%	Yes Yes	Yes Yes

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

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

Care Coordination℠ will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of Network and Non-Network Benefits is limited to 40 visits per calendar year. One visit equals four hours of skilled care services.

Notify Care Coordination℠

Please remember that you should notify Care Coordination℠ five business days before receiving services. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
10. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. **Notify Care Coordination℠** Please remember that you must notify Care Coordination℠ five business days before receiving services. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.	***Network*** Yes ***Non-Network*** Yes	10% 30%	Yes Yes	Yes Yes
11. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). **Notify Care Coordination℠** Please remember that you must notify Care Coordination℠ as follows: • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission.	***Network*** Yes ***Non-Network*** Yes	10% 30%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.				
12. Infertility Services Covered Health Services for the diagnosis and treatment of the underlying medical condition causing infertility when provided by or under the direction of a Physician.	***Network*** No	10%	Yes	Yes
	Non-Network No	30%	Yes	Yes
13. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	***Network*** No	*Office Visit:* $15 per visit	No	No
		Injection Only: 10%	Yes	Yes
	Non-Network No	30% per injection	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
14. Maternity Services Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify Care Coordination℠ during the first trimester, but no later than one month prior to the anticipated childbirth. We will pay Benefits for an Inpatient Stay of at least: • 48 hours for the mother and newborn child following a vaginal delivery. • 96 hours for the mother and newborn child following a cesarean section delivery. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. **Notify Care Coordination℠** Please remember that you must notify Care Coordination℠ as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If you don't notify Care Coordination℠ that the Inpatient Stay will be extended, your Benefits for the extended stay will be subject to a $300 penalty.	***Network*** Yes if Inpatient Stay exceeds time frames. ***Non-Network*** Yes if Inpatient Stay exceeds time frames.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services. Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.		

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
15. Mental Health and Substance Abuse Services - Outpatient Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy). • Crisis intervention. • Psychological testing.	***Network*** No	10%	Yes	Yes
Any combination of Network and Non-Network Benefits for Mental Health Services and/or Substance Abuse Services is limited to 50 visits per calendar year.	***Non-Network*** No	30%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16. Mental Health and Substance Abuse Services - Inpatient and Intermediate Mental Health Services and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being. The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. Network Benefits for Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services and Substance Abuse Services. Any combination of Network and Non-Network Benefits for Mental Health Services and/or Substance Abuse Services is limited to 30 days per calendar year.	***Network*** You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	10%	Yes	Yes
	Non-Network You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	30%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Authorization Required Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number appears on your ID card. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.				
17. Nutritional Counseling Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include: • Diabetes mellitus. • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias. Benefits are limited to three individual sessions during a Covered Person's lifetime for each medical condition.	***Network*** No ***Non-Network*** No	10% 30%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
18. Outpatient Surgery Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including surgery and related services. Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services* below. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	***Network*** No	10%	Yes	Yes
	Non-Network No	30%	Yes	Yes
19. Physician's Office Services Covered Health Services received in a Physician's office including: • Treatment of a Sickness or Injury. • Preventive medical care. • Voluntary family planning. • Well-baby and well-child care. • Routine well woman examinations, including pap smears, pelvic examinations and mammograms. • Routine well man examinations, including PSA examinations.	***Network*** No	$15 per visit No Copayment applies when no Physician charge is assessed.	No	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Routine physical examinations, including vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment or the fitting or purchase of eyeglasses or contact lenses.) • Immunizations.				
Network Benefits for immunizations where there is no Physician charge assessed are 10%.	***Non-Network*** No	30% No Benefits for preventive care.	Yes	Yes
20. Private Duty Nursing Covered Health Services for private duty nursing care given on an outpatient basis when provided by a licensed nurse (R.N., L.P.N., or L.V.N.).	***Network*** No	10%	Yes	Yes
Benefits are limited to a maximum of $5,000 per Covered Person per calendar year.	***Non-Network*** No	30%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
21. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.	***Network*** No	10%	Yes	Yes
When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	***Non-Network*** No	30%	Yes	Yes
22. Prosthetic Devices Prosthetic devices that replace a limb or body part including: • Artificial limbs. • Artificial eyes. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.	***Network*** No	10%	Yes	Yes
If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the direction of a Physician. We provide Benefits for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of each type of prosthetic device every five calendar years.	***Non-Network*** No	30%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
23. Reconstructive Procedures Reconstructive procedures - services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.	***Network*** Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		
Cosmetic Procedures - services are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function like breathing. This Plan does not provide Benefits for Cosmetic Procedures. Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to improve appearance and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in	***Non-Network*** Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
appearance is the primary purpose of the procedure. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. You can contact Care Coordination℠ at the telephone number on your ID card for more information about Benefits for mastectomy-related services. **Notify Care Coordination℠** Please remember that you should notify Care Coordination℠ five business days before receiving services. When you provide notification, Care Coordination℠ can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage.				
24. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy. • Occupational therapy. • Speech therapy. • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy.	***Network*** No	*Office Visit:* $15 *Alternate Setting:* 10%	No Yes	No Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. ***Speech Therapy for Children under Age Three*** Services of a licensed speech therapist for treatment given to a child under age three whose speech is impaired due to one of the following conditions: • Infantile autism. • Development delay or cerebral palsy. • Hearing impairment. Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate. Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.	***Non-Network*** No	30%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Any combination of Network and Non-Network Benefits is limited as follows: • 20 visits of physical therapy per calendar year. • 20 visits of occupational therapy per calendar year. • 20 visits of speech therapy per calendar year.				
25. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Any combination of Network and Non-Network Benefits is limited to 120 days per calendar year. Please note that, in general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting. The Covered Person is expected to improve to a predictable level of recovery.	***Network*** Yes	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are required intermittently (such as physical therapy three times a week). Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence. (Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)				
Notify Care Coordination℠ Please remember that you must notify Care Coordination℠ as follows: • For elective admissions: five business days before admission. • For non-elective admission: within one business day or the same day of admission. • For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.	***Non-Network*** Yes	30%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
26. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Network or non-Network Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day. Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Any combination of Network and Non-Network Benefits for Spinal Treatment is limited to 20 visits per calendar year.	***Network*** No	$15	No	No
	Non-Network No	30%	Yes	Yes
27. Temporomandibular Joint Dysfunction (TMJ) Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident,	***Network*** No	Office Visit: $15	No	No
		Alternate Setting: 10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
trauma, congenial defect, developmental defect, or orpathology. Please note that Benefits are not available for charges of services that are Dental in nature. A combination of Network and Non-Network Benefits is limited to a maximum of $1,500 per Covered Person per lifetime for non-surgical services and supplies relating to TMJ.	***Non-Network*** No	30%	Yes	Yes
28. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Physician. For the highest level of Benefits, transplantation services must be received at a Designated United Resource Network Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational Service or an Unproven Service. Care Coordination℠ notification is required for all transplant services. The services described under **Transportation and Lodging** below are Covered Health Services **ONLY** in connection with a transplant received at a Designated United Resource Network Facility. • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone	***Network*** Yes	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated United Resource Network Facility. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of $25,000 is payable for all charges made in connection with the search. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants. • Liver transplants. • Liver/small bowel transplants. • Pancreas transplants. • Small bowel transplants.				
Benefits for cornea transplants that are provided by a Physician at a Network Hospital are paid as if the transplant was received at a Designated United Resource Network Facility. We do not require that cornea transplants be performed at a Designated United Resource Network Facility in order for you to receive the highest level of Network Benefits.	***Non-Network*** Yes	30%	Yes	Yes
Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by Care Coordination to be a proven procedure for the involved diagnoses.				
Under the Plan there are specific guidelines regarding Benefits for				

transplant services. Contact Care Coordination℠ at the telephone number on your ID card for information about these guidelines.

Transportation and Lodging

Care Coordination℠ will assist the patient and family with travel and lodging arrangements only when services are received from a Designated United Resource Network Facility. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

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

There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation, lodging and meal

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures. **Notify Care Coordination℠** You must notify Care Coordination℠ as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.				
29. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.	***Network*** No	10%	Yes	Yes
	Non-Network No	30%	Yes	Yes

Section 2: What's Not Covered--Exclusions

This section contains information about:

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

How We Use Headings in this Section

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

Plan Exclusions

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

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

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

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

A. Alternative Treatments

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

B. Comfort or Convenience

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

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

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

C. Dental

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

D. Drugs

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

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

4. Over the counter drugs and treatments.

E. Experimental or Investigational Services or Unproven Services

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

F. Foot Care

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

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.

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

H. Mental Health/Substance Abuse

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

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

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

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

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

services, treatments, items or supplies provided for in (Section 1: Covered Health Services) may be covered.

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

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Except as described in (Section 1: What's Covered -- Benefits) under *Nutritional Counseling,* nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs.
3.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms.) Examples include:
   - — Pharmacological regimens, nutritional procedures or treatments.
   - — Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - — Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).

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3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental Injury in excess of one per lifetime, up to a maximum of $500.

K. Providers

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

   This exclusion does not apply to mammography testing.

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L. Infertility/Reproduction

1. Surrogate parenting.
2. The reversal of voluntary sterilization.
3. Fees or direct payment to a donor for sperm or ovum donations.
4. Fees relating to Assisted Reproductive Technology. (Such as Artificial Insemination, Invitro Fertilization, GIFT & ZIFT)
5. Monthly fees for maintenance and/or storage of frozen embryos.
6. Health services associated with an elective abortion or the use of non-surgical or drug-induced Pregnancy termination.
7. Contraceptive supplies and services.
8. Fetal reduction surgery.
9. Health services associated with the use of non-surgical or drug-induced Pregnancy termination.

M. Services Provided under Another Plan

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

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

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3. Health services while on active military duty.

N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer.
5. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in (Section 1: What's Covered--Benefits), unless determined by Care Coordination to be a proven procedure for the involved diagnoses.

O. Travel

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

P. Vision and Hearing

1. Purchase cost of eye glasses, contact lenses, or hearing aids.
2. Fitting charge for hearing aids, eye glasses or contact lenses.
3. Eye exercise therapy.

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

4. Routine vision examinations.
5. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - — Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - — Related to judicial or administrative proceedings or orders.
   - — Conducted for purposes of medical research.
   - — Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.

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7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature, including oral appliances.
9. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment *except as* a treatment of temporomandibular joint or obstructive sleep apnea.
11. Non-surgical treatment of obesity, including morbid obesity.
12. Surgical treatment of obesity including severe morbid obesity (with a BMI greater than 35).
13. Growth hormone therapy.
14. Sex transformation operations.
15. Custodial Care.
16. Domiciliary care.
17. Private duty nursing received on an inpatient basis.
18. Respite care.
19. Rest cures.
20. Psychosurgery.
21. Treatment of benign gynecomastia (abnormal breast enlargement in males).
22. Medical and surgical treatment of excessive sweating (hyperhidrosis).
23. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

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

24. Appliances for snoring.
25. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
26. Any charges relating to a Physician visit that was performed in the Covered Person's home.
27. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
28. Any charge for services, supplies or equipment advertised by the provider as free.
29. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
30. Any charges prohibited by federal anti-kickback or self-referral statutes.
31. Any additional charges submitted after payment has been made and your account balance is zero.
32. Any outpatient facility charge in excess of payable amounts under Medicare.
33. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
34. Outpatient rehabilitation services, Spinal Treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
35. Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies.
36. Speech therapy to treat stuttering, stammering, or other articulation disorders.

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37. Liposuction.
38. Chelation therapy, except to treat heavy metal poisoning.
39. Personal trainer.
40. Naturalist.

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Section 3: Description of Network and Non-Network Benefits

This section includes information about:

- Network Benefits.
- Non-Network Benefits.
- Your responsibility for notification.
- Emergency Health Services.

Network Benefits

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

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

Please note that Mental Health and Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee.

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

Please see (Section 1: What's Covered--Benefits) under the heading for *Mental Health and Substance Abuse.*

Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	A higher level of Benefits means less cost to you. See (Section 1: What's Covered--Benefits).	A lower level of Benefits means more cost to you. See (Section 1: What's Covered--Benefits).
Who Should Notify Care Coordination℠	You must notify Care Coordination℠ for certain Covered Health Services. Failure to notify results in reduced Benefits or no Benefits. See (Section 1: What's Covered--Benefits), under the *Must You Notify Care Coordination℠?* column.	You must notify Care Coordination℠ for certain Covered Health Services. Failure to notify results in reduced Benefits or no Benefits. See (Section 1: What's Covered--Benefits), under the *Must You Notify Care Coordination℠?* column.
Who Should File Claims	Not required. We pay Network providers directly.	You must file claims. See (Section 5: How to File a Claim).

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	Network	Non-Network
Outpatient Emergency Health Services	Emergency Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means that if you seek Emergency care at a non-Network facility, you are not required to meet the Annual Deductible or to pay any difference between Eligible Expenses and the amount the provider bills.	

Provider Network

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

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

Separately, you will automatically be given a directory of Network providers at no cost to you. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You are responsible for verifying a provider's Network status prior to receiving services, even when you are referred by another Network provider. You can verify the provider's status by calling the Claims Administrator.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

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

Designated United Resource Network Facilities and Other Providers

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

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

Non-Network Benefits

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by non-Network Physicians or non-Network providers. Non-Network Benefits are also payable for Covered Health Services that are provided at non-Network facilities. If there is no Network Provider within a 30 mile radius of your home zip code or no Network Specialist within a 50 mile radius of your home zip code, you may be eligible to receive benefits for certain Covered Health Services paid at the Network level. You may check a provider's status in your area by visiting www.myuhc.com or by calling Customer Service at the number on the back of your ID

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card. All benefits that fall under this category must be approved prior to receipt of care and are subject to any plan limitations or exclusions set forth in this SPD.

Your Responsibility for Notification

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

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

Care Coordination[SM]

When you notify Care Coordination[SM] as described above, they will work with you to implement the Care Coordination[SM] process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

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

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

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Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person must complete an online enrollment through YBR (Your Benefits Resources) website or by calling the iPeople Center within 31 days of eligibility or during Annual Enrollment. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

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

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

If You Are Eligible for Medicare

You will be responsible for the costs that Medicare would have paid if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

If you are enrolled in a Medicare+Choice (Medicare Part C) plan, you will be responsible for any additional costs or reduced benefits that result if you fail to follow the requirements of the Medicare+Choice plan. Please see *Medicare Eligibility* in (Section 9: General Legal Provisions) for more information about how Medicare may affect your Benefits.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	Eligible Person usually refers to an Employee or Retiree who meets the eligibility rules of this Plan. When an Eligible Person actually enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person and Participant, see (Section 10: Glossary of Defined Terms). If both spouses are Eligible Persons of the Plan Sponsor, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both. Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll without our written permission.	Cinergy Corp. determines who is eligible to enroll under the Plan.
Dependent	Dependent generally refers to the Participant's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms). Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent.	Cinergy Corp. determines who qualifies as a Dependent.

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date of hire or qualified status change if you complete an online enrollment through YBR (Your Benefits Resource) or by calling the iPeople Center within 31 days of the date the Eligible Person becomes eligible to enroll.
Open Enrollment Period	Eligible Persons may enroll themselves and their Dependents.	Cinergy Corp. determines the Open Enrollment Period. Coverage begins on the 1st day of the following calendar year.
New Eligible Persons	New Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date of the qualified status change if you enroll through the YBR (Your Benefit Resource) website or by calling the iPeople Center within 31 days of the event.
Adding New Dependents	Participants may enroll Dependents who join their family because of any of the following events: • Birth. • Legal adoption. • Placement for adoption. • Marriage. • Legal guardianship. • Court or administrative order.	Coverage begins on the date of the qualified status change if you enroll through the YBR (Your Benefit Resource) website or by calling the iPeople Center within 31 days of the event.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because required contributions were not paid on a timely basis.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

A special enrollment period applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - — Loss of eligibility (including, without limitation, legal separation, divorce or death).
  - — The employer stopped paying the contributions.
  - — In the case of COBRA continuation coverage, the coverage ended.

Event Takes Place (for example, a birth or marriage). Coverage begins on the date of the event if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the event.

Missed Initial Enrollment Period or Open Enrollment Period. Coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

Section 5: How to File a Claim

This section provides you with information about:

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

If You Receive Covered Health Services from a Network Provider

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

Filing a Claim for Benefits

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us through the Claims Administrator. You must file the claim in a format that contains all of the information required, as described below.

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

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

Required Information

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

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

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

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- Provider of service Name, Address and Tax Identification Number

E. The date the Injury or Sickness began.

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

Payment of Benefits

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

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

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

Benefit Determinations

Post-Service Claims

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

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

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

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

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

Pre-Service Claims

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

Urgent Claims that Require Immediate Action

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment

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could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

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

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

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

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

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

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Concurrent Care Claims

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

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

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Section 6: Questions and Appeals

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

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

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

What to Do First

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

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

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

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

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

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

Appeal Process

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

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

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

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

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

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

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

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from us as the Plan Administrator. Your second level appeal request must be submitted to us in writing within 60 days from receipt of the first level appeal decision.

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

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

Urgent Claim Appeals that Require Immediate Action

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

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

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

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Section 7: Coordination of Benefits

This section provides you with information about:

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

Benefits When You Have Coverage under More than One Plan

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

When Coordination of Benefits Applies

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

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the Benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

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Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Order of Benefit Determination Rules

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

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

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

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

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

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

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the Coverage Plan covering the person as an Employee, Retiree or Dependent is secondary and the other Coverage Plan is primary.

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

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

1) The parents are married;

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

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

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

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

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

1) The Coverage Plan of the custodial parent;

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

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

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

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a Dependent of a person covered as a Retiree or an Employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a Dependent of an actively working spouse will be determined under the rule labeled D(1).
4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an Employee or Retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored.
5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an Employee or Retiree longer is primary.
6. If a husband or wife is covered under this Coverage Plan as a Participant and as an Enrolled Dependent, the Dependent Benefits will be coordinated as if they were provided under another Coverage Plan, this means the Participant's benefit will pay first.
7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

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Effect on the Benefits of this Plan

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

1. Determine its obligation to pay or provide Benefits under its contract;
2. Determine whether a benefit reserve has been recorded for the Covered Person; and
3. Determine whether there are any unpaid Allowable Expenses during that claim determination period.

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

B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, Benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.
C. This Coverage Plan reduces its Benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

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Medicare Benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled for Medicare. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare Benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

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

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

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Coverage Plan. We will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means reasonable cash value of the Benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the Benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

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Section 8: When Coverage Ends

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

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

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

General Information about When Coverage Ends

We may discontinue this Benefit Plan and/or all similar benefit Plans at any time, as permitted or required by law.

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

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

With the exception of a surviving spouse of the Participant, an Enrolled Dependent's coverage ends on the date the Participant's coverage ends or sooner if the Participant chooses to end the Dependent's coverage or as otherwise set forth in this SPD.

In some cases, you may have the right and option to choose to continue coverage at your expense, even though you may no longer qualify as an Employee, Retiree or Dependent. For more information on this issue, see this section's discussion of Continuation of coverage under federal law (COBRA).

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

Events Ending Your Coverage

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

Ending Event	What Happens
The Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms "Eligible Person", "Participant", "Dependent" and "Enrolled Dependent."
The Claims Administrator Receives Notice to End Coverage	Your coverage ends on the last day of the calendar month in which the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
Participant Retires or Is Pensioned	The coverage that you have as an Employee may be available to you in retirement. The Cinergy iPeople Center can provide you with this information as well as explain how to elect coverage as a retiree.

Other Events Ending Your Coverage

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

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

Coverage for a Handicapped Child

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

- Is not able to be self-supporting because of mental retardation or physical handicap.
- Depends mainly on the Participant for support.

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

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

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

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

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

For purposes of the Plan, a person who meets the definition of a Handicapped Child, as just explained, shall be considered a Dependent for coverage purposes.

Continuation of Coverage

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

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

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

Continuation Coverage under Federal Law (COBRA)

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

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

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

Qualifying Events for Continuation Coverage under COBRA

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

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

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Notification Requirements and Election Period for Continuation Coverage under COBRA

The Participant or other Qualified Beneficiary must notify the Plan Administrator within 60 days of the Participant's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Participant or other Qualified Beneficiary fails to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Participant is continuing coverage under federal law, the Participant must notify the Plan Administrator within 60 days of the birth or adoption of a child.

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

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

COBRA Terminating Events

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

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

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

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

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

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

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E. The date, after electing continuation coverage, that coverage is first obtained under any other group health Plan.

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

G. The date the entire Plan ends.

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

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

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

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

Section 9: General Legal Provisions

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

Plan Document

This document is the Plan document and the Summary Plan Description.

Relationship with Providers

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

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

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

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

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

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

Your Relationship with Providers

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

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

Incentives to Providers

The Claims Administrator pays Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

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Examples of financial incentives for Network providers are:

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

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

Incentives to You

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

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

Interpretation of Benefits

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

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

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

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

Administrative Services

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

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Amendments to the Plan

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

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

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

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. The terms of this Plan may not be amended by oral statements made by the Plan Sponsor, the Plan Administrative Committee, the Claims Administrator, or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

Information and Records

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

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

We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers

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may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we or the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan Administrator.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

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

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

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If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in (Section 7: Coordination of Benefits), we will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare+Choice (Medicare Part C) Plan on a primary basis (Medicare pays before Benefits under the Plan), you **should** follow all rules of that Plan that require you to seek services from that Plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare+Choice Plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, the Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits the Plan provided to Covered Persons, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Summary Plan Description, the Plan shall

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also have an independent right to be reimbursed by Covered Persons for the reasonable value of any services and Benefits the Plan provides to Covered Persons, from any or all of the following listed below.

- Third parties, including any person alleged to have caused a Covered Person to suffer injuries or damages.
- Any person or entity who is or may be obligated to provide Benefits or payments to a Covered Person, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to a Covered Person on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties".

Covered Persons agree as follows:

- That a Covered Person will cooperate with the Plan in a timely manner in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by the Plan,
  - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - appearing at depositions and in court, and
  - obtaining the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and/or the institution of legal action against a Covered Person.
- That the Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a Covered Person to pursue his or her damage/personal injury claim.
- That regardless of whether a Covered Person have been fully compensated or made whole, the Plan may collect from Covered Persons the proceeds of any full or partial recovery that a Covered Person or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection shall include, but not be limited to any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by the Plan may also be considered to be benefits advanced.

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- That Covered Persons agree that if they receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, the Covered Person will serve as a constructive trustee over the funds and failure to hold such funds in trust will be deemed as a breach of the Covered Persons duties hereunder.

- That Covered Persons or an authorized agent, such as the Covered Person's attorney, must hold any funds received from any potentially responsible party that are due and owed to the Plan, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the institution of legal action against the Covered Person.

- That the Plan shall be entitled to recover reasonable attorney fees from Covered Persons incurred in collecting from the Covered Person any funds held by the Covered Person that he or she recovered from any Third Party.

- That the Plan may set off from any future benefits otherwise allowed by the Plan the value of benefits paid or advanced under this section to the extent not recovered by the Plan.

- That Covered Persons will neither accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval, nor will the Covered Person do anything to prejudice the Plan's rights under this section.

- That Covered Persons will assign to the Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits the Plan provided, plus reasonable costs of collection.

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- That the Plan's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom Covered Persons are seeking recovery, to be paid before any other of the Covered Person's claims are paid.

- That the Plan's rights will not be reduced due to the Covered Person's own negligence.

- That the Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the Covered Persons name, which does not obligate the Plan in any way to pay the Covered Person part of any recovery the Plan might obtain.

- That the Plan shall not be obligated in any way to pursue this right independently or on behalf of the Covered Person.

- That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.

- That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan beneficiary, this section applies to the personal representative of the deceased Plan beneficiary.

Refund of Overpayments

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

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.

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- All or some of the payment we made exceeded the Benefits under the Plan.

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

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

Limitation of Action

You cannot bring any legal action against us or the Claim Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in (Section 5: How to File a Claim) and all required reviews of your claim have been completed. If you want to bring a legal action against us or the Claims Administrator you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us or the Claims Administrator.

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

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Section 10: Glossary of Defined Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not

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Covered--Exclusions), including Experimental or Investigational Services and Unproven Services.

Covered Health Services must be provided:

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

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

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

Custodial Care - services that:

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

Dependent - the Participant's legal spouse or an unmarried Dependent child of the Participant or the Participant's spouse, including a surviving spouse, if such spouse remains unmarried from the time of the Employee's or Retiree's death. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A Handicapped Child, as described in (Section 8: When Coverage Ends).
- A child for whom legal guardianship has been awarded to the Participant or the Participant's spouse.

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

- A Dependent includes any unmarried Dependent child under 19 years of age.
- A Dependent includes an unmarried Dependent child who is 19 years of age or older, but less than 25 years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - — The child must not be regularly employed on a full-time basis.
  - — The child must be a Full-time Student.
  - — The child must be primarily Dependent upon the Participant for support and maintenance.

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

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

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

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

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

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

Eligible Expenses are based on either of the following:

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- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers, unless you receive services as a result of an Emergency, Eligible Expenses are determined at the Claims Administrator's discretion by either (1) calculating Eligible Expenses based on available data resources of competitive fees in that geographic area, or (2) applying the negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors.

Eligible Expenses are determined solely in accordance with the Claim Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claim Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

Eligible Person - a regular full-time Employee of the Plan Sponsor who is scheduled to work at his or her job at least 20 hours per week or otherwise considered by the Plan Sponsor to be an Employee for

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

Plan coverage purposes; or a person who retires while covered under the Plan.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

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

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

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

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

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.

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- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

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

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

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, beautician school automotive school or similar training school.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case,

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

the provider will be a Network provider for the Health Services and products included in the participation agreement, and a non-Network provider for other Health Services and products. The participation status of providers will change from time to time.

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

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

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

Out-of-Pocket Maximum - the maximum amount you pay out-of-pocket every calendar year after the Annual Deductible is met. If you use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Depending on the geographic area and the service you receive, you may have access to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, your Coinsurance for Non-Network Benefits will remain the same, however the total amount that you owe may be less than if you received services from other non-Network providers because the Eligible Expenses may be a lesser amount.

Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year.

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

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

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

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

- Any charges for non-Covered Health Services.
- The amount of any reduced Benefits if you don't notify Care Coordination℠ as described in (Section 1: What's Covered--Benefits) under the *Must You Notify Care Coordination℠?* column.
- Charges that exceed Eligible Expenses.

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

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

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

Plan - United HealthCare High PPO Plan for Cinergy Corp. Health Benefit Plan.

Plan Administrator - is the Cinergy Corp. or its designee as that term is defined under ERISA.

Plan Sponsor - Cinergy Corp.. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Pregnancy - includes all of the following:

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

Retiree - any person who retires from Cinergy and is determined and approved by the Plan Sponsor to be eligible to receive coverage under the Plan as a Retiree.

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

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

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

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

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

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

Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

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

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

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- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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

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

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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RIGHT HAND PAGE

Riders, Amendments, Notices

Attachment I

Attachment II

Attachment I

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

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

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

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

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

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Attachment II

Summary Plan Description

Name of Plan: Cinergy Corp. Health & Welfare Benefits Plan, as it relates to the United HealthCare High PPO Plan for Cinergy Corp; Group Number 239203

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

Cinergy Corp.
139 East Fourth Street
Cincinnati, OH 45202
(513) 287-3333

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

Employer Identification Number (EIN): 31-1385023

IRS Plan Number: 506

Effective Date of Plan: January 1, 2004

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Type of Plan: Self-insured health and welfare benefits plan, offering group health plan benefits to Employees, Retirees and their Dependents

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

Cinergy Corp.
139 East Fourth Street
Cincinnati, OH 45202
(513) 287-3333

Claims Administrator: The following entity provides certain administrative services for the Plan.

United HealthCare Insurance Company
450 Columbus Blvd.
Hartford, CT 06115-0450

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

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Person designated as agent for service of legal process: Service of process may also be made upon the Plan Administrator.

Source of contributions under the Plan: There are no contributions to the Plan. All Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required Participant contributions are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

Method of calculating the amount of contribution: Participant-required contributions to the Plan Sponsor are the Participant's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required Participant contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to Participants.

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

Determinations of Qualified Medical Child Support Orders.

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

Although the Plan Sponsor currently intends to continue the Benefits provided by this Plan, the Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add Benefits or terminate this Plan or this Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or Amendment to or termination

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of the Plan, its Benefits or its terms and condition, in whole or in part, shall be made solely in a written Amendment (in the case of a change or Amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The Amendment or resolution is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or Amendments to the Plan.

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

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

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

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

Receive Information About Your Plan and Benefits

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

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Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

Continue Group Health Plan Coverage

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

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

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coverage. you should know that, currently, the Plan does not impose any pre-existing condition limitations or exclusions.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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SCI DOC ID 478862
RIGHT HAND PAGE

Summary Plan Description

United HealthCare Medium PPO Plan

for

Cinergy Corp.

Group Number: 239203

Effective Date: January 1, 2004

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Introduction

We are pleased to provide you with this Summary Plan Description (SPD). This SPD describes your Benefits, as well as your rights and responsibilities, under the Plan.

How to Use this Document

We encourage you to read your SPD and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitation of this SPD by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions). You should also carefully read (Section 9: General Legal Provisions) to better understand how this SPD and your Benefits work. You should call the Claims Administrator if you have questions about the limits of the coverage available to you.

Many of the sections of the SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. We encourage you to keep your SPD and any attachments for your future reference.

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

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Information about Defined Terms

Because this SPD is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 10: Glossary of Defined Terms). You can refer to Section 10 as you read this document to have a clearer understanding of your SPD.

When we use the words "we," "us," and "our" in this document, we are referring to the Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in (Section 10: Glossary of Defined Terms).

Your Contribution to the Benefit Costs

The Plan may require the Participant to contribute to the cost of coverage. Contact your Benefits representative for information about any part of this cost you may be responsible for paying.

Customer Service and Claims Submittal

Please make note of the following information that contains Claims Administrator department names and telephone numbers.

Customer Service Representative (questions regarding Coverage or procedures): As shown on your ID card.

Care Coordination℠/Notification: As shown on your ID card.

Mental Health/Substance Abuse Services Designee: As shown on your ID card.

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Claims Submittal Address:

United HealthCare Insurance Company

PO Box 740800

Atlanta, GA 30374-0800

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Insurance Company

PO Box 740816

Atlanta, GA 30374-0816

Internet:

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

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).
- Covered Health Services that require you to notify Care Coordination℠ before you receive them.

Accessing Benefits

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits you must see a Network Physician or other Network provider.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive. For details about when Network Benefits apply, see (Section 3: Description of Network and Non-Network Benefits).

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

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

Copayment

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment, see (Section 10: Glossary of Defined Terms). Copayment amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Copayments are calculated as a percentage (rather than as a set dollar amount) the percentage is based on Eligible Expenses.

Eligible Expenses

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

We have delegated to the Claims Administrator the discretion and authority to initially determine on our behalf whether a treatment or

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supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

For Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills, unless you agreed to reimburse the provider for such services. For non-Network Benefits, except for fees that are negotiated by a non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

Notification Requirements

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

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

Services for which you must provide prior notification appear in this section under the *Must You Notify Care Coordination[SM]?* column in the table labeled *Benefit Information.* Some of the services requiring notification include:

- Accidental Dental Services.
- Durable Medical Equipment over $1,000.
- Home Health Care.
- Hospice Care.
- Hospital Confinements.
- Maternity Care that exceeds 48 hours for normal delivery and 96 hours for Caesarian birth.

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- Inpatient Mental Health and Substance Abuse Services.
- Reconstructive Procedures.
- Skilled Nursing/Inpatient Rehabilitation Facility Confinement.
- Transplant Services.
- Breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature.

To notify Care Coordination[SM] or the Mental Health/Substance Abuse Designee, call the telephone number on your ID card for Claims Administration.

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

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

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

Special Note Regarding Medicare

If you are enrolled for Medicare on a primary basis (Medicare pays before we pay Benefits under the Plan), the notification requirements described in this SPD do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in (Section 7: Coordination of Benefits). You are not required to notify Care Coordination℠ before receiving Covered Health Services when Medicare is the primary payer.

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

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

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms).	***Network*** $500 per Covered Person per calendar year, not to exceed $1,000 for all Covered Persons in a family.
	Covered Expenses charged by both Network and non-network Providers apply towards both the Network Individual and Family Deductibles and the non-network Individual and Family Deductibles.	***Non-Network*** $1,000 per Covered Person per calendar year, not to exceed $2,000 for all Covered Persons in a family.
Copayment	The charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses.	***Network and Non-Network*** See each Benefit in **Section 1: What's Covered - - Benefits** for further information.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	***Network*** $1,500 per Covered Person per calendar year, not to exceed $3,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.
	Covered Expenses charged by both Network and non-network Providers	***Non-Network*** $3,000 per Covered Person per calendar year, not to exceed $6,000 for all

Payment Term	Description	Amounts
	apply towards both the Network Individual and Family Out-of-Pocket Maximums and the non-network Individual Family Out-of-Pocket Maximums.	Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.
Maximum Plan Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Plan. For a complete definition of Maximum Plan Benefit, see (Section 10: Glossary of Defined Terms).	***Network and Non-Network*** $2,000,000 per Covered Person.

Benefit Information

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services Acupuncture services for pain therapy when both of the following are true: • Another method of pain management has failed. • The service is performed by a provider in the provider's office. Where such Benefits are available, acupuncture is a Covered Health Service for the treatment of: • Nausea of Chemotherapy, or • Post-operative nausea, or • Nausea of early Pregnancy. Any combination of Network and Non-Network Benefits is limited to 20 visits per calendar year.	***Network*** No ***Non-Network*** No	$20 per visit 40%	No Yes	No Yes
2. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	***Network*** No	*Ground Transportation:* 20% *Air Transportation:* 20%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
	Non-Network No	Same as Network	Same as Network	Same as Network
3. Ambulance Services - Non-Emergency Transportation by professional ambulance, other than air ambulance, to and from a medical facility. Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment.	***Network*** No	*Ground Transportation:* 20% *Air Transportation:* 20%	Yes	Yes
Note: Except in life threatening circumstances, notification for Air Ambulance transport is required	***Non-Network*** No	20%	Yes	Yes
4. Christian Science Practitioner Covered Health Services rendered when:	***Network*** Not Covered	Not Covered	Not Covered	Not Covered
• The frequency is reasonable and comparable to treatment by another health care provider.				
• The Christian Science Nurse or Practitioner is listed in the Christian Science Journal at the time the charge is made.	***Non-Network*** No	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
5. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 48 hours of the accident. Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be both of the following: • Started within three months of the accident. • Completed within 12 months of the accident. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to	***Network*** Yes ***Non-Network*** Yes	*Office Visit:* $20 *Alternate Setting:* 20% 40%	Yes Yes Yes	Yes Yes Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
teeth that are injured as a result of such activities. **Notify Care Coordination℠** Please remember that you should notify Care Coordination℠ as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.) When you provide notification, Care Coordination℠ can verify that the service is a Covered Health Service.				
6. Diagnostic and Therapeutic Services Covered Health Services received on an outpatient basis including: • Lab and radiology/X-ray. • Mammography testing. • Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy). A standard test (such as a Mammogram, PSA or Pap Smear) associated with an annual preventative screening will be covered at 100%. If additional follow-up testing is required, the standard Copayment will apply. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	***Network*** No ***Non-Network*** No	20% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
7. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment. Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen concentrator units and the rental of equipment to administer oxygen. • Delivery pumps for tube feedings. • Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service, including necessary adjustments to shoes to accommodate braces. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions.	***Network*** Yes, for items more than $1,000. ***Non-Network*** Yes, for items more than $1,000.	20% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Diabetic pumps. We provide Benefits for a single unit of Durable Medical Equipment (example one insulin pump) and provide repair for that unit. Benefits are provided for the replacement of a type of Durable Medical Equipment once every three calendar years. Care Coordination℠ will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor Care Coordination℠ identifies. **Notify Care Coordination℠** Please remember that you must notify Care Coordination℠ before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item). If you don't notify Care Coordination℠, Benefits for Durable Medical Equipment will be subject to a $300 penalty.				
8. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits). The $75 Emergency Health Services Copayment is waived if the Covered Person is admitted to a Hospital. Additionally, no Benefits	***Network*** Yes, but only for an Inpatient Stay. ***Non-Network*** Yes, but only for an Inpatient Stay.	$75 per visit Same as Network	No Same as Network	No Same as Network

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
are provided if the service is deemed to be non-Emergency in nature. **Notify Care Coordination℠** To ensure prompt and accurate payment of your claim as a Network Benefit, notify Care Coordination℠ within two business days or as soon as possible after you receive outpatient Emergency Health Services at a non-Network Hospital or Alternate Facility. Please remember that if you are admitted to a Hospital as a result of an Emergency, you must notify Care Coordination℠ within two business days or the same day of admission, or as soon as reasonably possible. If you don't notify Care Coordination℠, Benefits for the Hospital Inpatient Stay will be subject to a $300 penalty. Benefits will not be reduced for the outpatient Emergency Health Services.				
9. Home Health Care Services received from a Home Health Agency that are both of the following: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.	***Network*** Yes ***Non-Network*** Yes	20% 40%	Yes Yes	Yes Yes

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

Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

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

Care Coordination℠ will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of Network and Non-Network Benefits is limited to 40 visits per calendar year. One visit equals four hours of skilled care services.

Notify Care Coordination℠

Please remember that you should notify Care Coordination℠ five business days before receiving services. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
10. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency.	***Network*** Yes	20%	Yes	Yes
Notify Care Coordination℠ Please remember that you must notify Care Coordination℠ five business days before receiving services. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.	***Non-Network*** Yes	40%	Yes	Yes
11. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds).	***Network*** Yes	20%	Yes	Yes
Notify Care Coordination℠ Please remember that you must notify Care Coordination℠ as follows: • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission.	***Non-Network*** Yes	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.				
12. Infertility Services Covered Health Services for the diagnosis and treatment of the underlying medical condition causing infertility when provided by or under the direction of a Physician.	***Network*** No	20%	Yes	Yes
	Non-Network No	40%	Yes	Yes
13. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	***Network*** No	*Office Visit:* $20 per visit	No	No
		Injection Only: 20%	Yes	Yes
	Non-Network No	40% per injection	Yes	Yes

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

14. Maternity Services

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

There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify Care Coordination℠ during the first trimester, but no later than one month prior to the anticipated childbirth.

We will pay Benefits for an Inpatient Stay of at least:

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

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Notify Care Coordination℠

Please remember that you must notify Care Coordination℠ as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If you don't notify Care Coordination℠ that the Inpatient Stay will be extended, your Benefits for the extended stay will be subject to a $300 penalty.

Network	Yes if Inpatient Stay exceeds time frames.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.	
Non-Network	Yes if Inpatient Stay exceeds time frames.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.	

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
15. Mental Health and Substance Abuse Services - Outpatient Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy). • Crisis intervention. • Psychological testing.	***Network*** No	20%	Yes	Yes
Any combination of Network and Non-Network Benefits for Mental Health Services and/or Substance Abuse Services is limited to 50 visits per calendar year.	***Non-Network*** No	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16. Mental Health and Substance Abuse Services - Inpatient and Intermediate Mental Health Services and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being. The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. Network Benefits for Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services and Substance Abuse Services. Any combination of Network and Non-Network Benefits for Mental Health Services and/or Substance Abuse Services is limited to 30 days per calendar year.	***Network*** You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	20%	Yes	Yes
	Non-Network You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Authorization Required Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number appears on your ID card. Without authorization, you will be responsible for paying all charges. and no Benefits will be paid.				
17. Nutritional Counseling Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include: • Diabetes mellitus. • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias. Benefits are limited to three individual sessions during a Covered Person's lifetime for each medical condition.	***Network*** No ***Non-Network*** No	20% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
18. Outpatient Surgery Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including surgery and related services. Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services* below. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	***Network*** No ***Non-Network*** No	20% 40%	Yes Yes	Yes Yes
19. Physician's Office Services Covered Health Services received in a Physician's office including: • Treatment of a Sickness or Injury. • Preventive medical care. • Voluntary family planning. • Well-baby and well-child care. • Routine well woman examinations, including pap smears, pelvic examinations and mammograms. • Routine well man examinations, including PSA examinations. • Routine physical examinations, including vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment or the fitting or purchase of eyeglasses or contact lenses.) • Immunizations.	***Network*** No	$20 per visit No Copayment applies when no Physician charge is assessed.	No	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Network Benefits for immunizations where there is no Physician charge assessed are 20%.	***Non-Network*** No	40% No Benefits for preventive care.	Yes	Yes
20. Private Duty Nursing Covered Health Services for private duty nursing care given on an outpatient basis when provided by a licensed nurse (R.N., L.P.N., or L.V.N.).	***Network*** No	20%	Yes	Yes
Benefits are limited to a maximum of $5,000 per Covered Person per calendar year.	***Non-Network*** No	40%	Yes	Yes
21. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.	***Network*** No	20%	Yes	Yes
When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	***Non-Network*** No	40%	Yes	Yes

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

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

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify Care Coordination℠ Please remember that you should notify Care Coordination℠ five business days before receiving services. When you provide notification, Care Coordination℠ can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage.				
24. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy. • Occupational therapy. • Speech therapy. • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.	***Network*** No ***Non-Network*** No	*Office Visit:* $20 *Alternate Setting:* 20% 40%	No Yes Yes	No Yes Yes

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

Speech Therapy for Children under Age Three

Services of a licensed speech therapist for treatment given to a child under age three whose speech is impaired due to one of the following conditions:

- Infantile autism.
- Development delay or cerebral palsy.
- Hearing impairment.

Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Any combination of Network and Non-Network Benefits is limited as follows:

- 20 visits of physical therapy per calendar year.
- 20 visits of occupational therapy per calendar year.
- 20 visits of speech therapy per calendar year.

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
25. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Any combination of Network and Non-Network Benefits is limited to 120 days per calendar year. Please note that, in general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting. The Covered Person is expected to improve to a predictable level of recovery. Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are required intermittently (such as physical therapy three times a week). Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is	***Network*** Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence. (Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)				
Notify Care Coordination℠ Please remember that you must notify Care Coordination℠ as follows: • For elective admissions: five business days before admission. • For non-elective admission: within one business day or the same day of admission. • For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.	***Non-Network*** Yes	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
26. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Network or non-Network Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day. Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Any combination of Network and Non-Network Benefits for Spinal Treatment is limited to 20 visits per calendar year.	***Network*** No ***Non-Network*** No	$20 40%	No Yes	No Yes
27. Temporomandibular Joint Dysfunction (TMJ) Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary	***Network*** No	Office Visit: $20 Alternate Setting: 20%	No Yes	No Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
diagnostic or surgical treatment required as a result of accident, trauma, congenial defect, developmental defect, or orpathology. Please note that Benefits are not available for charges of services that are Dental in nature. A combination of Network and Non-Network Benefits is limited to a maximum of $1,500 per Covered Person per lifetime for non-surgical services and supplies relating to TMJ.	***Non-Network*** No	40%	Yes	Yes
28. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Physician. For the highest level of Benefits, transplantation services must be received at a Designated United Resource Network Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational Service or an Unproven Service. Care Coordination℠ notification is required for all transplant services. The services described under **Transportation and Lodging** below are Covered Health Services **ONLY** in connection with a transplant received at a Designated United Resource Network Facility. • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the	***Network*** Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
definition of a Covered Health Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated United Resource Network Facility. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of $25,000 is payable for all charges made in connection with the search.				
• Heart transplants.				
• Heart/lung transplants.				
• Lung transplants.				
• Kidney transplants.				
• Kidney/pancreas transplants.				
• Liver transplants.				
• Liver/small bowel transplants.				
• Pancreas transplants.				
• Small bowel transplants.				
Benefits for cornea transplants that are provided by a Physician at a Network Hospital are paid as if the transplant was received at a Designated United Resource Network Facility. We do not require that cornea transplants be performed at a Designated United Resource Network Facility in order for you to receive the highest level of Network Benefits.	***Non-Network*** Yes	40%	Yes	Yes
Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by Care Coordination to be a proven procedure for the involved				

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

diagnoses.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact Care Coordination℠ at the telephone number on your ID card for information about these guidelines.

Transportation and Lodging

Care Coordination℠ will assist the patient and family with travel and lodging arrangements only when services are received from a Designated United Resource Network Facility. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

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

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures. **Notify Care Coordination℠** You must notify Care Coordination℠ as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.				
29. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.	***Network*** No	20%	Yes	Yes
	Non-Network No	40%	Yes	Yes

Section 2: What's Not Covered--Exclusions

This section contains information about:

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

How We Use Headings in this Section

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

Plan Exclusions

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

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

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

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

A. Alternative Treatments

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

B. Comfort or Convenience

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

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

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

C. Dental

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

D. Drugs

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

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

4. Over the counter drugs and treatments.

E. Experimental or Investigational Services or Unproven Services

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

F. Foot Care

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

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.

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

H. Mental Health/Substance Abuse

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

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

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

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any services, treatments, items or supplies provided for in (Section 1: Covered Health Services) may be covered.

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

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Except as described in (Section 1: What's Covered -- Benefits) under *Nutritional Counseling,* nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms.) Examples include:
   - — Pharmacological regimens, nutritional procedures or treatments.
   - — Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - — Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).

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3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental Injury in excess of one per lifetime, up to a maximum of $500.

K. Providers

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

   This exclusion does not apply to mammography testing.

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L. Infertility/Reproduction

1. Surrogate parenting.
2. The reversal of voluntary sterilization.
3. Fees or direct payment to a donor for sperm or ovum donations.
4. Fees relating to Assisted Reproductive Technology. (Such as Artificial Insemination, Invitro Fertilization, GIFT & ZIFT)
5. Monthly fees for maintenance and/or storage of frozen embryos.
6. Health services associated with an elective abortion or the use of non-surgical or drug-induced Pregnancy termination.
7. Contraceptive supplies and services.
8. Fetal reduction surgery.
9. Health services associated with the use of non-surgical or drug-induced Pregnancy termination.

M. Services Provided under Another Plan

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

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

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3. Health services while on active military duty.

N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer.
5. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in (Section 1: What's Covered--Benefits), unless determined by Care Coordination to be a proven procedure for the involved diagnoses.

O. Travel

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

P. Vision and Hearing

1. Purchase cost of eye glasses, contact lenses, or hearing aids.
2. Fitting charge for hearing aids, eye glasses or contact lenses.
3. Eye exercise therapy.

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4. Routine vision examinations.
5. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - — Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - — Related to judicial or administrative proceedings or orders.
   - — Conducted for purposes of medical research.
   - — Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.

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7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature, including oral appliances.
9. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment *except as* a treatment of temporomandibular joint or obstructive sleep apnea.
11. Non-surgical treatment of obesity, including morbid obesity.
12. Surgical treatment of obesity including severe morbid obesity (with a BMI greater than 35).
13. Growth hormone therapy.
14. Sex transformation operations.
15. Custodial Care.
16. Domiciliary care.
17. Private duty nursing received on an inpatient basis.
18. Respite care.
19. Rest cures.
20. Psychosurgery.
21. Treatment of benign gynecomastia (abnormal breast enlargement in males).
22. Medical and surgical treatment of excessive sweating (hyperhidrosis).
23. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

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24. Appliances for snoring.
25. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
26. Any charges relating to a Physician visit that was performed in the Covered Person's home.
27. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
28. Any charge for services, supplies or equipment advertised by the provider as free.
29. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
30. Any charges prohibited by federal anti-kickback or self-referral statutes.
31. Any additional charges submitted after payment has been made and your account balance is zero.
32. Any outpatient facility charge in excess of payable amounts under Medicare.
33. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
34. Outpatient rehabilitation services, Spinal Treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
35. Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies.
36. Speech therapy to treat stuttering, stammering, or other articulation disorders.

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37. Liposuction
38. Chelation therapy, except to treat heavy metal poisoning.
39. Personal trainer.
40. Naturalist.

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Section 3: Description of Network and Non-Network Benefits

This section includes information about:

- Network Benefits.
- Non-Network Benefits.
- Your responsibility for notification.
- Emergency Health Services.

Network Benefits

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

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

Please note that Mental Health and Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee.

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Please see (Section 1: What's Covered--Benefits) under the heading for *Mental Health and Substance Abuse.*

Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	A higher level of Benefits means less cost to you. See (Section 1: What's Covered--Benefits).	A lower level of Benefits means more cost to you. See (Section 1: What's Covered--Benefits).
Who Should Notify Care Coordination℠	You must notify Care Coordination℠ for certain Covered Health Services. Failure to notify results in reduced Benefits or no Benefits. See (Section 1: What's Covered--Benefits), under the *Must You Notify Care Coordination℠?* column.	You must notify Care Coordination℠ for certain Covered Health Services. Failure to notify results in reduced Benefits or no Benefits. See (Section 1: What's Covered--Benefits), under the *Must You Notify Care Coordination℠?* column.
Who Should File Claims	Not required. We pay Network providers directly.	You must file claims. See (Section 5: How to File a Claim).

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	Network	Non-Network
Outpatient Emergency Health Services	Emergency Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means that if you seek Emergency care at a non-Network facility, you are not required to meet the Annual Deductible or to pay any difference between Eligible Expenses and the amount the provider bills.	

Provider Network

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

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

Separately, you will automatically be given a directory of Network providers at no cost to you. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You are responsible for verifying a provider's Network status prior to receiving services, even when you are referred by another Network provider. You can verify the provider's status by calling the Claims Administrator.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

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

Designated United Resource Network Facilities and Other Providers

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

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

Non-Network Benefits

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by non-Network Physicians or non-Network providers. Non-Network Benefits are also payable for Covered Health Services that are provided at non-Network facilities. If there is no Network Provider within a 30 mile radius of your home zip code or no Network Specialist within a 50 mile radius of your home zip code, you may be eligible to receive benefits for certain Covered Health Services paid at the Network level. You may check a provider's status in your area by visiting www.myuhc.com or by calling Customer Service at the number on the back of your ID

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card. All benefits that fall under this category must be approved prior to receipt of care and are subject to any plan limitations or exclusions set forth in this SPD.

Your Responsibility for Notification

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

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

Care Coordination℠

When you notify Care Coordination℠ as described above, they will work with you to implement the Care Coordination℠ process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

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

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

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Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person must complete an online enrollment through YBR (Your Benefits Resources) website or by calling the iPeople Center within 31 days of eligibility or during Annual Enrollment. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

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

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

If You Are Eligible for Medicare

You will be responsible for the costs that Medicare would have paid if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

If you are enrolled in a Medicare+Choice (Medicare Part C) plan, you will be responsible for any additional costs or reduced benefits that result if you fail to follow the requirements of the Medicare+Choice plan. Please see *Medicare Eligibility* in (Section 9: General Legal Provisions) for more information about how Medicare may affect your Benefits.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	Eligible Person usually refers to an Employee or Retiree who meets the eligibility rules of this Plan. When an Eligible Person actually enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person and Participant, see (Section 10: Glossary of Defined Terms). If both spouses are Eligible Persons of the Plan Sponsor, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both. Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll without our written permission.	Cinergy Corp. determines who is eligible to enroll under the Plan.
Dependent	Dependent generally refers to the Participant's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms). Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent.	Cinergy Corp. determines who qualifies as a Dependent.

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date of hire or qualified status change if you complete an online enrollment through YBR (Your Benefits Resource) or by calling the iPeople Center within 31 days of the date the Eligible Person becomes eligible to enroll.
Open Enrollment Period	Eligible Persons may enroll themselves and their Dependents.	Cinergy Corp. determines the Open Enrollment Period. Coverage begins on the 1st day of the following calendar year.
New Eligible Persons	New Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date of the qualified status change if you enroll through the YBR (Your Benefit Resource) website or by calling the iPeople Center within 31 days of the event.
Adding New Dependents	Participants may enroll Dependents who join their family because of any of the following events: • Birth. • Legal adoption. • Placement for adoption.	Coverage begins on the date of the qualified status change if you enroll through the YBR (Your Benefit Resource) website or by calling the iPeople Center within 31 days of the event.

- Marriage.
- Legal guardianship.
- Court or administrative order.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because required contributions were not paid on a timely basis.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

A special enrollment period applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - — Loss of eligibility (including, without limitation, legal separation, divorce or death).
  - — The employer stopped paying the contributions.
  - — In the case of COBRA continuation coverage, the coverage ended.

Event Takes Place (for example, a birth or marriage). Coverage begins on the date of the event if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the event.

Missed Initial Enrollment Period or Open Enrollment Period. Coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

Section 5: How to File a Claim

This section provides you with information about:

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

If You Receive Covered Health Services from a Network Provider

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

Filing a Claim for Benefits

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us through the Claims Administrator. You must file the claim in a format that contains all of the information required, as described below.

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

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

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

Required Information

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

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

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

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- Provider of service Name, Address and Tax Identification Number

E. The date the Injury or Sickness began.

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

Payment of Benefits

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

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

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

Benefit Determinations

Post-Service Claims

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

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

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

Pre-Service Claims

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

Urgent Claims that Require Immediate Action

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment

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could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

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

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

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

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

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

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Concurrent Care Claims

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

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

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Section 6: Questions and Appeals

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

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

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

What to Do First

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

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

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

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

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

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

Appeal Process

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

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

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

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

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

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

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

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from us as the Plan Administrator. Your second level appeal request must be submitted to us in writing within 60 days from receipt of the first level appeal decision.

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

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

Urgent Claim Appeals that Require Immediate Action

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

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

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

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Section 7: Coordination of Benefits

This section provides you with information about:

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

Benefits When You Have Coverage under More than One Plan

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

When Coordination of Benefits Applies

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

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the Benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

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Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

1) The parents are married;

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

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

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

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

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

1) The Coverage Plan of the custodial parent;

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

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

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

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a Dependent of a person covered as a Retiree or an Employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a Dependent of an actively working spouse will be determined under the rule labeled D(1).
4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an Employee or Retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored.
5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an Employee or Retiree longer is primary.
6. If a husband or wife is covered under this Coverage Plan as a Participant and as an Enrolled Dependent, the Dependent Benefits will be coordinated as if they were provided under another Coverage Plan, this means the Participant's benefit will pay first.
7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

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Effect on the Benefits of this Plan

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

   1. Determine its obligation to pay or provide Benefits under its contract;
   2. Determine whether a benefit reserve has been recorded for the Covered Person; and
   3. Determine whether there are any unpaid Allowable Expenses during that claim determination period.

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

B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, Benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.
C. This Coverage Plan reduces its Benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

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Medicare Benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled for Medicare. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare Benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

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

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

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Coverage Plan. We will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means reasonable cash value of the Benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the Benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

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Section 8: When Coverage Ends

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

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

General Information about When Coverage Ends

We may discontinue this Benefit Plan and/or all similar benefit Plans at any time, as permitted or required by law.

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

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

With the exception of a surviving spouse of the Participant, an Enrolled Dependent's coverage ends on the date the Participant's coverage ends or sooner if the Participant chooses to end the Dependent's coverage or as otherwise set forth in this SPD.

In some cases, you may have the right and option to choose to continue coverage at your expense, even though you may no longer qualify as an Employee, Retiree or Dependent. For more information on this issue, see this section's discussion of Continuation of coverage under federal law (COBRA).

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Events Ending Your Coverage

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

Ending Event	What Happens
The Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms "Eligible Person", "Participant", "Dependent" and "Enrolled Dependent."
The Claims Administrator Receives Notice to End Coverage	Your coverage ends on the last day of the calendar month in which the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
Participant Retires or Is Pensioned	The coverage that you have as an Employee may be available to you in retirement. The Cinergy iPeople Center can provide you with this information as well as explain how to elect coverage as a retiree.

Other Events Ending Your Coverage

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

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

Coverage for a Handicapped Child

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

- Is not able to be self-supporting because of mental retardation or physical handicap.
- Depends mainly on the Participant for support.

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

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

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

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

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

For purposes of the Plan, a person who meets the definition of a Handicapped Child, as just explained, shall be considered a Dependent for coverage purposes.

Continuation of Coverage

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

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

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

Continuation Coverage under Federal Law (COBRA)

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

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

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

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

Qualifying Events for Continuation Coverage under COBRA

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

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

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

Notification Requirements and Election Period for Continuation Coverage under COBRA

The Participant or other Qualified Beneficiary must notify the Plan Administrator within 60 days of the Participant's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Participant or other Qualified Beneficiary fails to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Participant is continuing coverage under federal law, the Participant must notify the Plan Administrator within 60 days of the birth or adoption of a child.

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

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

COBRA Terminating Events

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

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

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

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

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

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

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

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

E. The date, after electing continuation coverage, that coverage is first obtained under any other group health Plan.

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

G. The date the entire Plan ends.

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

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

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

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

Section 9: General Legal Provisions

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

Plan Document

This document is the Plan document and the Summary Plan Description.

Relationship with Providers

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

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

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

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

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

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

Your Relationship with Providers

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

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

Incentives to Providers

The Claims Administrator pays Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

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Examples of financial incentives for Network providers are:

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

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

Incentives to You

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

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

Interpretation of Benefits

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

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

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

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

Administrative Services

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

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

Amendments to the Plan

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

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

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

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. The terms of this Plan may not be amended by oral statements made by the Plan Sponsor, the Plan Administrative Committee, the Claims Administrator, or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

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

Information and Records

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

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

We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers

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may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we or the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan Administrator.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

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

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

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If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in (Section 7: Coordination of Benefits), we will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare+Choice (Medicare Part C) Plan on a primary basis (Medicare pays before Benefits under the Plan), you **should** follow all rules of that Plan that require you to seek services from that Plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare+Choice Plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, the Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits the Plan provided to Covered Persons, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Summary Plan Description, the Plan shall

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

also have an independent right to be reimbursed by Covered Persons for the reasonable value of any services and Benefits the Plan provides to Covered Persons, from any or all of the following listed below.

- Third parties, including any person alleged to have caused a Covered Person to suffer injuries or damages.
- Any person or entity who is or may be obligated to provide Benefits or payments to a Covered Person, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to a Covered Person on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties".

Covered Persons agree as follows:

- That a Covered Person will cooperate with the Plan in a timely manner in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by the Plan,
  - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - appearing at depositions and in court, and
  - obtaining the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and/or the institution of legal action against a Covered Person.
- That the Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a Covered Person to pursue his or her damage/personal injury claim.
- That regardless of whether a Covered Person have been fully compensated or made whole, the Plan may collect from Covered Persons the proceeds of any full or partial recovery that a Covered Person or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection shall include, but not be limited to any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by the Plan may also be considered to be benefits advanced.

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- That Covered Persons agree that if they receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, the Covered Person will serve as a constructive trustee over the funds and failure to hold such funds in trust will be deemed as a breach of the Covered Persons duties hereunder.

- That Covered Persons or an authorized agent, such as the Covered Person's attorney, must hold any funds received from any potentially responsible party that are due and owed to the Plan, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the institution of legal action against the Covered Person.

- That the Plan shall be entitled to recover reasonable attorney fees from Covered Persons incurred in collecting from the Covered Person any funds held by the Covered Person that he or she recovered from any Third Party.

- That the Plan may set off from any future benefits otherwise allowed by the Plan the value of benefits paid or advanced under this section to the extent not recovered by the Plan.

- That Covered Persons will neither accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval, nor will the Covered Person do anything to prejudice the Plan's rights under this section.

- That Covered Persons will assign to the Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits the Plan provided, plus reasonable costs of collection.

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- That the Plan's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom Covered Persons are seeking recovery, to be paid before any other of the Covered Person's claims are paid.

- That the Plan's rights will not be reduced due to the Covered Person's own negligence.

- That the Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the Covered Persons name, which does not obligate the Plan in any way to pay the Covered Person part of any recovery the Plan might obtain.

- That the Plan shall not be obligated in any way to pursue this right independently or on behalf of the Covered Person.

- That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.

- That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan beneficiary, this section applies to the personal representative of the deceased Plan beneficiary.

Refund of Overpayments

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

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.

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- All or some of the payment we made exceeded the Benefits under the Plan.

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

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

Limitation of Action

You cannot bring any legal action against us or the Claim Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in (Section 5: How to File a Claim) and all required reviews of your claim have been completed. If you want to bring a legal action against us or the Claims Administrator you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us or the Claims Administrator.

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

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Section 10: Glossary of Defined Terms

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

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

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

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

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

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

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

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

Claims Administrator - the company, or its affiliate, that provides certain claim administration services for the Plan.

Congenital Anomaly - a physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Copayment - the charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by Care Coordination℠ on our behalf.

Covered Health Service(s) -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not

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Covered--Exclusions), including Experimental or Investigational Services and Unproven Services.

Covered Health Services must be provided:

- When the Plan is in effect;
- Prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Covered Person - either the Participant or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Participant's legal spouse or an unmarried Dependent child of the Participant or the Participant's spouse,

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including a surviving spouse, if such spouse remains unmarried from the time of the Employee's or Retiree's death. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A Handicapped Child, as described in (Section 8: When Coverage Ends).
- A child for whom legal guardianship has been awarded to the Participant or the Participant's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any unmarried Dependent child under 19 years of age.
- A Dependent includes an unmarried Dependent child who is 19 years of age or older, but less than 25 years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - — The child must not be regularly employed on a full-time basis.
  - — The child must be a Full-time Student.
  - — The child must be primarily Dependent upon the Participant for support and maintenance.

The Participant must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

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A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order, including a National Medical Support Notice. We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order or a National Medical Support Notice.

Designated United Resource Network Facility - a Hospital that the Claims Administrator names as a Designated United Resource Network Facility. A Designated United Resource Network Facility has entered into an agreement with the Claims Administrator to render Covered Health Services for the treatment of specified diseases or conditions. A Designated United Resource Network Facility may or may not be located within our geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated United Resource Network Facility.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.

Eligible Expenses - the amount we will pay for Covered Health Services, incurred while the Plan is in effect, which are determined as stated below:

Eligible Expenses are based on either of the following:

To continue reading, go to right column on this page.

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers, unless you receive services as a result of an Emergency, Eligible Expenses are determined at the Claims Administrator's discretion by either (1) calculating Eligible Expenses based on available data resources of competitive fees in that geographic area, or (2) applying the negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors.

Eligible Expenses are determined solely in accordance with the Claim Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claim Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Eligible Person - a regular full-time Employee of the Plan Sponsor who is scheduled to work at his or her job at least 20 hours per week or otherwise considered by the Plan Sponsor to be an Employee for

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Plan Coverage purposes; or a person who retires while covered under the Plan.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Employee - an Eligible Person who is properly enrolled under the Plan. The Employee is the person (who is not a Dependent) on whose behalf the Plan is established.

Enrolled Dependent - a Dependent who is properly enrolled under the Plan.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.

To continue reading, go to right column on this page.

- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Full-time Student - a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, beautician school automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student at the end of the calendar month you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

To continue reading, go to left column on next page.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law, that is both of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time, as determined by the Plan Administrator, during which Eligible Persons may enroll themselves and their Dependents under the Plan.

Injury.- bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

To continue reading, go to right column on this page.

Maximum Plan Benefit - the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Plan, or any other Plan of the Plan Sponsor. When the Maximum Plan Benefit applies, it is described in (Section 1: What's Covered--Benefits).

Medicare - Parts A, B, and C of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Abuse Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available under the Plan.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect with the Claims Administrator or an affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case,

To continue reading, go to left column on next page.

the provider will be a Network provider for the Health Services and products included in the participation agreement, and a non-Network provider for other Health Services and products. The participation status of providers will change from time to time.

Network Benefits - Benefits for Covered Health Services that are provided by a Network Physician or other Network provider.

Non-Network Benefits - Benefits for Covered Health Services that are provided by a non-Network Physician or other non-Network provider.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Plan. The Plan Administrator will determine the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - the maximum amount you pay out-of-pocket every calendar year after the Annual Deductible is met. If you use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Depending on the geographic area and the service you receive, you may have access to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, your Coinsurance for Non-Network Benefits will remain the same, however the total amount that you owe may be less than if you received services from other non-Network providers because the Eligible Expenses may be a lesser amount.

Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year.

To continue reading, go to right column on this page.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider.
- Any Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.
- The amount of any reduced Benefits if you don't notify Care Coordination℠ as described in (Section 1: What's Covered--Benefits) under the *Must You Notify Care Coordination℠?* column.
- Charges that exceed Eligible Expenses.
- Any amounts applied towards meeting your Annual Deductible.

Even when the Out-of-Pocket Maximum has been reached, the following will not be paid at 100%:

- Any charges for non-Covered Health Services.
- The amount of any reduced Benefits if you don't notify Care Coordination℠ as described in (Section 1: What's Covered--Benefits) under the *Must You Notify Care Coordination℠?* column.
- Charges that exceed Eligible Expenses.

Participant - an Eligible Person who is properly enrolled under the Plan. The Participant is the person (who is not a Dependent) on whose behalf the Plan is established.

Physician - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

To continue reading, go to left column on next page.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - United HealthCare Medium PPO Plan for Cinergy Corp. Health Benefit Plan.

Plan Administrator - is the Cinergy Corp. or its designee as that term is defined under ERISA.

Plan Sponsor - Cinergy Corp.. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Retiree - any person who retires from Cinergy and is determined and approved by the Plan Sponsor to be eligible to receive coverage under the Plan as a Retiree.

Rider - any attached written description of additional Covered Health Services not described in this SPD. Riders are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

To continue reading, go to right column on this page.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Spinal Treatment - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

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- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and the Claims Administrator may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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RIGHT HAND PAGE

Riders, Amendments, Notices

Attachment I

Attachment II

Attachment I

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

To continue reading, go to right column on this page.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Group health Plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require than a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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Attachment II

Summary Plan Description

Name of Plan: Cinergy Corp. Health & Welfare Benefits Plan, as it relates to the United HealthCare Medium PPO Plan for Cinergy Corp; Group Number 239203

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Cinergy Corp.

139 East Fourth Street
Cincinnati, OH 45202
(513) 287-3333

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Employer Identification Number (EIN): 31-1385023

IRS Plan Number: 506

Effective Date of Plan: January 1, 2004

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Type of Plan: Self-insured health and welfare benefits plan, offering group health plan benefits to Employees, Retirees and their Dependents.

Name, Business address, and Business Telephone Number of Plan Administrator:

Cinergy Corp.
139 East Fourth Street
Cincinnati, OH 45202
(513) 287-3333

Claims Administrator: The following entity provides certain administrative services for the Plan.

United HealthCare Insurance Company
450 Columbus Blvd.
Hartford, CT 06115-0450

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of Benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Sponsor also has selected a Provider Network established by United HealthCare Insurance Company. The named fiduciary of Plan is Cinergy Corporation, the Plan Sponsor.

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Person designated as agent for service of legal process: Service of process may also be made upon the Plan Administrator.

Source of contributions under the Plan: There are no contributions to the Plan. All Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required Participant contributions are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

Method of calculating the amount of contribution: Participant-required contributions to the Plan Sponsor are the Participant's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required Participant contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to Participants.

Date of the end of the year for purposes of maintaining Plan's fiscal records: Plan year shall be a twelve month period ending December 31.

Determinations of Qualified Medical Child Support Orders.

The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Although the Plan Sponsor currently intends to continue the Benefits provided by this Plan, the Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add Benefits or terminate this Plan or this Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or Amendment to or termination

To continue reading, go to right column on this page.

of the Plan, its Benefits or its terms and condition, in whole or in part, shall be made solely in a written Amendment (in the case of a change or Amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The Amendment or resolution is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or Amendments to the Plan.

Benefits under the Plan are furnished in accordance with the Plan Description issued by the Plan Sponsor, including this Summary Plan Description.

Participant's rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the procedures to be followed in regard to denied claims or other complaints relating to the Plan are set forth in the body of this Summary Plan Description.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S.

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Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another group health Plan. In addition, if your Plan coverage ceases, you have the right to be provided a certificate of creditable coverage, free of charge, from the Plan, as well as any other group health plan or health insurance issuer when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. You should know that, currently, the Plan does not impose any pre-existing condition limitations or exclusions.

To continue reading, go to right column on this page.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court after all required reviews of your claim have been completed. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the

To continue reading, go to left column on next page.

U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Pension and Welfare Benefits Administration.

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CINERGY SERVICES, INC.

HUMANA STANDARD PLAN

HMO MEDICAL BENEFITS

EFFECTIVE JANUARY 1, 2004
REVISED JANUARY 1, 2006

SUMMARY PLAN DESCRIPTION
of the
GROUP HEALTH PLAN
sponsored by
CINERGY SERVICES, INC.

The Plan Sponsor has established and continues to maintain this Group Health Plan (the "Plan") for the benefit of its Employees, Retirees and their eligible Dependents as provided in this document.

The coverage provided under the Plan is not in lieu of and does not affect any requirements for coverage by Workers' Compensation.

Benefits under this Plan are provided on a self-insured basis, which means that payment for benefits is ultimately the sole financial responsibility of the Plan Sponsor. Certain administrative services with respect to the Plan, such as claims processing, are provided under a service agreement with Humana Insurance Company (also referred to as the "Plan Manager"). The Plan Manager is not responsible, nor will it assume responsibility, for benefits payable under the Plan.

This Summary Plan Description provides You with detailed information regarding Your coverage. It spells out what is covered and what is not covered. It also identifies Your duties and how much You must pay when obtaining services. Although Your coverage is broad in scope, it is important to remember that Your coverage is not without limitations. Be sure to read Your Summary Plan Description carefully ***before*** making use of Your benefits.

Any changes in the Plan, as presented in this Summary Plan Description, must be properly adopted by the Plan Sponsor, and material modifications must be timely disclosed in writing and included in or attached to this document. A verbal modification of the Plan, or promise having the same effect, made by any person will not be binding with respect to the Plan.

Any provision of this Summary Plan Description which is in conflict with the laws or regulations of the jurisdiction in which it is issued, delivered, or renewed is hereby amended to conform to the minimum requirements of such laws or regulations.

Participating Providers are not agents or employees of Humana Insurance Company. When requesting authorizations from Humana Insurance Company and ordering services, participating Physicians and other Participating Providers are acting on Your behalf. Humana Insurance Company is not responsible for any misstatements made by any Participating Provider with regard to the scope of covered services available under Your Summary Plan Description. If You have any questions concerning the scope of coverage, please call Humana's service center.

When You review this Summary Plan Description, You will notice that some terms are capitalized each time they are used. These terms are defined in the "Definitions" section of Your Summary Plan Description. These definitions are part of the Summary Plan Description. Defined terms should be read in light of any special meanings given them in the Definitions.

We realize that You may still have questions as You read this Summary Plan Description. The Humana Service Center is available to be of service to You and will do its utmost to assure that Your questions are answered.

We provide health care coverage to Members equally, without regard to race, color, religion, sex or national origin.

Plan Number: 226363
Effective Date: January 1, 2006

QUESTIONS?

The Humana Service Center

Although most of the information You need regarding Your coverage and the benefits available to You and any of Your covered family members can be found in Your Summary Plan Description, there may be some times when You need additional information or clarification about Your coverage or Humana practices and procedures.

If You have any questions regarding Your coverage and Your benefits, You can call Humana at the number listed on Your Member identification card.

Service specialists are available to answer Your questions and assist You in the following areas:

- General information pertaining to coverage, emergencies, Copayments, and Physician selection;
- Name/address changes;
- Benefits/Summary Plan Description clarification;
- Access to health care services; and
- Conditions or situations not listed in Your Summary Plan Description.

If You Are Covered By More Than One Health Plan

Notice: If You or Your family members are covered by more than one health care plan, You may not be able to collect benefits from both plans. Each plan may require You to follow its rules or use specific doctors and Hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the "Coordination of Benefits" section, and compare them with the rules of any other plan that covers You or Your family.

TABLE OF CONTENTS

DEFINITIONS

Here are some terms used in Your Summary Plan Description. Other terms may be defined in the sections that follow:

ACTIVE STATUS means performing on a regular, full-time or part-time basis all customary occupational duties for at least 20 hours per week.

ADMISSION means entry into a facility as a registered inpatient according to the rules and regulations of that facility. An Admission ends when the Member is discharged, or released, from the facility and is no longer registered as an inpatient.

AMBULATORY SURGICAL CENTER means an institution that meets all of the following requirements:

1. it must be operated by Physicians and a medical staff which includes registered nurses;
2. it must have permanent facilities and equipment for the primary purpose of performing surgical procedures;
3. it must provide continuous Physicians' services on an outpatient basis;
4. it must admit and discharge patients from the facility within the same work Day;
5. it must be licensed in accordance with the laws of the jurisdiction where it is located;
6. it must be run as an Ambulatory Surgical Center as defined by those laws; and
7. it must not be used for the primary purpose of terminating pregnancies or as an office or clinic for the private practice of any Physician or dentist.

APPROVED HEALTH CARE FACILITY OR APPROVED HEALTH CARE PROGRAM means a facility or program which is licensed, certified or otherwise authorized pursuant to the laws of the state in which the facility is located to provide health care. It must be approved by the Plan Manager or have entered into an agreement with the Plan Manager to provide the care described in the Summary Plan Description.

BREAST RECONSTRUCTION means the reconstruction of a breast on which a Medically Necessary mastectomy has been performed and the reconstruction of the non-diseased breast to achieve symmetry. The term also includes prostheses required for such reconstruction and treatment of physical complications of all stages of mastectomy including lymphedema, in a manner determined in consultation with the attending Participating Physician and the Member. Modification relating to achieving symmetry after the initial reconstruction must be Medically Necessary.

CALENDAR YEAR means the period of time which begins on any January 1st and ends on the following December 31st. When a person first becomes covered under the Plan, the first Calendar Year begins for him or her on the effective date of his or her coverage and ends on the December 31st coinciding with or next following his or her effective date.

CHILD means Your natural born or legally adopted Child. A Child who is in the custody of a principal enrollee, pursuant to an interim court order of adoption vesting temporary care of the Child, is an adopted Child, regardless of whether a final order granting adoption is ultimately issued. The term also includes any Child for whom You are the legal guardian; a Child who is dependent upon Your health care coverage pursuant to a valid court order, including a Medical Child Support Order (MCSO).

CLAIMANT means a Member (or authorized representative) who files a claim.

CONCURRENT CARE DECISION means a decision by the Plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the Plan (other than by Plan amendment or termination) or a decision with respect to a request by a Claimant to extend a course of treatment beyond the period of time or number of treatments that has been approved by the Plan.

Definitions Continued

CONFINEMENT means an uninterrupted stay of more than 16 hours in a Hospital, Skilled Nursing Facility or Approved Health Care Facility or Program followed by discharge from that same Hospital, Skilled Nursing Facility or Approved Health Care Facility or Program.

COPAYMENT means the charge, in addition to the Plan fee, which Members are required to pay for certain Health Services provided under the Summary Plan Description. The Member must make Copayments at the time of service directly to the Provider of the Health Services.

COVERED EXPENSE means services incurred by a Member due to Injury or Sickness for which benefits may be available under the Plan. Covered Expenses are subject to all provisions of the Plan, including the limitations and exclusions.

COVERED PERSON means the Employee, Retiree or any of their covered Dependents.

CREDITABLE COVERAGE means prior coverage by a Member under any of the following:

1. a group health plan, including church and governmental plans;
2. health insurance coverage;
3. Part A or Part B of Title XVII of the Social Security Act (Medicare);
4. Medicaid, other than coverage consisting solely of benefits under section 1928;
5. the health plan for active military personnel, including CHAMPUS;
6. the Indian Health Service or other tribal organization program;
7. a state health benefits risk pool;
8. the Federal Employees Health Benefits Program;
9. a public health plan as defined in federal regulations;
10. a health benefit plan under section 5(e) of the Peace Corps Act; and
11. any other plan which provides comprehensive Hospital, medical and surgical services.

Creditable Coverage does not include any of the following:

1. accident only coverage, disability income insurance or any combination thereof;
2. supplemental coverage to liability insurance;
3. liability insurance, including general liability insurance and automobile liability insurance;
4. workers' compensation or similar insurance;
5. automobile medical payment insurance;
6. credit-only insurance;
7. coverage for on-site medical clinics;
8. benefits if offered separately:
   a. limited scope dental and vision;
   b. long-term care, nursing home care, home health care, community based care or any combination thereof; and
   c. other similar, limited benefits;
9. benefits if offered as independent, non-coordinated benefits:
   a. specified disease of illness coverage; and
   b. Hospital indemnity or other fixed indemnity insurance;
10. benefits offered as a separate policy:
   a. Medicare supplement insurance;
   b. supplemental coverage to the health plan for active military personnel, including CHAMPUS; and
   c. similar supplement coverage provided to group health plan coverage.

DAY means a 24-hour period starting at 12:01 a.m. at the group's address.

Definitions Continued

DEPENDENT means a covered Employee's or Retiree's:

1. Legally recognized spouse;

2. Unmarried natural blood related Child, stepchild, legally adopted Child or Child placed with the Employee or Retiree for adoption, or Child for which the Employee or Retiree has legal guardianship whose age is less than the limiting age. Each Child must legally qualify as a Dependent as defined by the United States Internal Revenue Service.

   The limiting age for each Dependent Child is:

   a. 19 years; or
   b. 25 years if such Child is taking at least 9 hours at an accredited secondary school, college or university.

   Adopted children and children placed for adoption are subject to all terms and provisions of the Plan.

3. A covered Employee's or Retiree's Child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a Medical Child Support Order.

You must furnish satisfactory proof to the Plan Manager or Plan Sponsor upon request that the above conditions continuously exist. If satisfactory proof is not submitted to the Plan Manager, the Child's coverage will not continue beyond the last date of eligibility.

DETOXIFICATION TREATMENT means those Medically Necessary services which are required to physically withdraw, stabilize and evaluate an individual whose use of alcohol or addictive drugs is of such magnitude as to create a physical abstinence syndrome that cannot be safely managed on an ambulatory basis and which requires 24 hour observation and medical care, or those Medically Necessary services which are required to manage and evaluate an individual whose degree of intoxication with alcohol or psychoactive drugs has created significant impairment in judgment and motor function such that the care cannot be provided on an ambulatory basis and which requires 24 hour observation and medical care.

DIABETES EQUIPMENT means blood glucose monitors, including monitors designed to be used by blind individuals; insulin pumps and associated appurtenances; insulin infusion devices, and podiatric appliances for the prevention of complications associated with diabetes.

DIABETES SELF-MANAGEMENT TRAINING means training provided to a Member after the initial diagnosis of diabetes for care and management of the condition including nutritional counseling and use of Diabetes Equipment and supplies. It also includes training when changes required to the self-management regime and when new techniques and treatments are developed.

DURABLE MEDICAL EQUIPMENT means equipment which meets the following criteria:

1. it can stand repeated use;
2. it is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
3. it is usually not useful to a person in the absence of Sickness or Injury;
4. it is appropriate for home use;
5. it is related to the patient's physical disorder.

Definitions Continued

EMERGENCY MEDICAL CONDITION means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn Child, in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part;

With respect to a pregnant woman who is having contractions:

1. a situation in which there is inadequate time to effect a safe transfer to another Hospital before delivery; or
2. a situation in which transfer may pose a threat to the health or safety of the woman or the unborn Child.

EMPLOYEE means a person who is in an eligible class as defined by the Employer.

EMPLOYER means the sponsor of the Group Plan or any subsidiary(s).

EXPERIMENTAL OR INVESTIGATIONAL means a drug, biological product, device, medical treatment or procedure that meets any one of the following criteria, as determined by the Plan Manager:

1. **Reliable Evidence** shows the drug, biological product, device, medical treatment, or procedure when applied to the circumstances of a particular patient is the subject of ongoing phase I, II, or III clinical trials, or
2. **Reliable Evidence** shows the drug, biological product, device, medical treatment, or procedure when applied to the circumstances of particular patient is under study with a written protocol to determine maximum tolerate dose, toxicity, safety, efficacy, or efficacy in comparison to conventional alternatives, or
3. **Reliable Evidence** shows the drug, biological product, device, medical treatment, or procedure is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations particularly those of the U.S. Food and Drug Administration or the Department of Health and Human Services.
4. **Reliable Evidence** shall mean only published reports and articles in the authoritative medical and scientific literature; the PDQ database of the National Cancer Institute; the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, biological product, device, medical treatment or procedure; the written informed consent used by the treating facility or another facility studying substantially the same drug, biological product, device, medical treatment or procedure, or regulations and other official actions and publications issued by the U.S. Food and Drug Administration or the Department of Health and Human Services.

FAMILY MEMBER means You or Your spouse, or You or Your spouse's Child, brother, sister, parent, grandchild or grandparent.

FREE-STANDING SURGICAL FACILITY means a public or private establishment licensed to perform Surgery and which has permanent facilities that are equipped and operated primarily for the purpose of performing Surgery. It does not provide services or accommodations for patients to stay overnight.

HEALTH SERVICES means the health care services or supplies covered under the Summary Plan Description, except to the extent that such health care services and supplies are limited or excluded under the Summary Plan Description.

Definitions Continued

HEALTH STATUS-RELATED FACTOR means any of the following:

1. health status or medical history;
2. medical condition, either physical or mental;
3. claims experience;
4. receipt of health care;
5. genetic information;
6. disability; or
7. evidence of insurability, including conditions arising out of acts of domestic violence.

HOME HEALTH AGENCY means a facility or program which: (1) is licensed, certified or otherwise authorized pursuant to the laws of the jurisdiction where it is located as a Home Health Agency; and (2) is approved by the Plan Manager to provide the Health Service covered under the Summary Plan Description.

HOSPICE CARE PROGRAM means a coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Family Member and his or her covered Family Members, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. The hospice must be licensed by the laws of the jurisdiction where it is located and must be run as a hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a Physician, are expected to live less than 6 months as a result of that illness.

HOSPITAL means institution operated pursuant to law which: (1) is primarily engaged in providing, for compensation from its patients, diagnostic and surgical services for the care and treatment of injured or sick individuals by or under the supervision of a staff of Physicians; (2) has 24-hour nursing services by registered graduate nurses (R.N.'s); (3) is not primarily a place for rest, custodial care of the aged; and (4) is not a nursing home, convalescent home or similar institution.

INFERTILITY SERVICES means services or supplies given for the diagnosis and/or treatment of infertility.

INJURY means bodily damage resulting from an accident including all related conditions and recurrent symptoms.

LATE ENROLLEE means an Employee or Dependent that request enrollment in a health benefits Plan after the initial enrollment period. An individual will not be considered a Late Enrollee if:

1. the person enrolls during his/her initial enrollment period under the Plan; or
2. the person enrolls in the Plan during a special enrollment period; or
3. a court orders that coverage be provided for a minor child under a covered Employee's health benefits plan, but only as long as the person requests enrollment for such Dependent within 31 Days after the court order is issued.

MAINTENANCE CARE means any service or activity which seeks to prevent Injury or Sickness, prolong life, promote health or prevent deterioration of a Covered Person who has reached the maximum level of improvement or whose condition is resolved or stable.

MEDICAL GROUP means the health care professionals and practitioners employed by or contracted with by the Plan Manger to provide covered services to Members with the Plan Manager's facilities or Hospitals, or in the private offices of the Medical Group, as designated by the Plan Manager.

Definitions Continued

MEDICALLY NECESSARY means services and supplies which must be:

1. consistent with the symptom or diagnosis and treatment of the Member's Injury or Sickness;
2. appropriate with regard to standards of good medical practice;
3. not solely for the convenience of a Member, Physician, Hospital or ambulatory care facility; or
4. the most appropriate supply or level of service, which can be safely provided to the Member. When applied to the care of an inpatient, it further means that the Member's medical symptoms or condition require that the services cannot be safely provided to the Member on an outpatient basis.

MEDICARE means the insurance program established by Title 18, Social Security Act of 1965, as amended.

MEMBER means either You or Your Dependent, but applies only while coverage of such person under the Plan is in effect.

MENTAL HEALTH, ALCOHOLISM AND CHEMICAL DEPENDENCY SERVICES means those services and supplies covered under the Plan for the diagnosis and treatment of Mental Illness, Alcoholism and Chemical or Drug Dependencies, which are classified in the International Classification of Diseases of the U.S. Department of Health and Human Services.

MENTAL ILLNESS means a physical or mental condition having an emotional or psychological origin.

NON-PARTICIPATING ALTERNATE FACILITY means a facility that is physically, organizationally and financially separate from a Hospital which: (1) may provide outpatient surgical services, emergency services, urgent care services or other related outpatient treatment or diagnostic services; and (2) has not been designated as a Participating Provider under this Plan.

NON-PARTICIPATING HOSPITAL means a Hospital that has not been designated to provide services to Covered Persons under this Plan.

NON-PARTICIPATING PROVIDER means a Hospital, Pharmacy, Physician, or any other Health Services Provider who has not been designated to provide services under this Plan.

OPEN ENROLLMENT PERIOD means a period of time at least once a year determined by the Plan Sponsor during which Employees and Retirees may enroll themselves and their eligible Dependents.

ORAL SURGERY means procedures to correct diseases, injuries and defects of the jaw and mouth structures. These procedures include but are not limited to the following: (1) Surgical removal of full bony impactions; (2) Mandibular (staple) implant; (3) Maxillary or mandibular frenectomy; (4) Alveolectomy and alveoplasty; (5) Orthognathic Surgery; and (6) Periodontal Surgery including gingivectomies.

PARTICIPATING ALTERNATE FACILITY means a facility that is physically, organizationally, and financially separate from the Hospital which: (1) may provide outpatient surgical services, emergency services, urgent care services or other related outpatient treatment or diagnostic services; and (2) has been designated to provide services under this Plan.

PARTICIPATING HOSPITAL means a Hospital that has been designated to provide services to Covered Persons under this Plan.

PARTICIPATING PROVIDER means a Hospital, Pharmacy, Physician or any other Health Services Provider who has been designated to provide services to Covered Persons under this Plan.

Definitions Continued

PHYSICIAN means a duly licensed medical practitioner who is practicing within the scope of his or her license and whose services are required to be covered under the Plan by the laws of the State or other jurisdiction in which treatment is given.

PHYSICIAN NETWORK means a partnership, association, corporation, other legal entity or network of Physicians on staff at one of the Plan Manager's contracting Hospitals, as defined.

PLAN means the health care Plan as described herein.

PLAN ADMINISTRATOR means the Employer. Humana Insurance Company is not the Plan Administrator.

PLAN MANAGER means Humana Insurance Company (HIC). The Plan Manager provides services to the Plan Administrator, as defined under the Plan Management Agreement. The Plan Manager is not the Plan Administrator or the Plan Sponsor.

PLAN SPONSOR means Cinergy Services, Inc.

POST-SERVICE CLAIM means any claim for a benefit under a group health Plan that is not a Pre-Service Claim.

PRECERTIFICATION means the process of assessing the medical necessity, appropriateness, or utility of proposed non-emergency Hospital Admissions, surgical procedures, outpatient care, and other health care services.

PRE-SERVICE CLAIM means a claim with respect to which the terms of the Plan condition receipt of a Plan benefit, in whole or in part, on approval of the benefit by the Plan Manager in advance of obtaining medical care.

PRIMARY CARE PHYSICIAN means a licensed practitioner of medicine or osteopathy licensed by the jurisdiction where the treatment is given. The Primary Care Physician is a participating Physician who is responsible for providing, prescribing, directing and authorizing all care and treatment of a Member. Covered Services may be received from a specialist who is a Participating Provider without a referral.

PROTECTED HEALTH INFORMATION means individually identifiable health information about a Covered Person, including: (a) patient records, which includes but is not limited to all health records, Physician and Provider notes and bills and claims with respect to a Covered Person; (b) patient information, which includes patient records and all written and oral information received about a Covered Person; and (c) any other individually identifiable health information about Covered Persons.

PROVIDER means a facility or professional practitioner that is licensed according to law in the jurisdiction in which it, he or she is located or practices. With respect to a professional practitioner, he or she must be practicing within the scope of license and the services involved must be required to be covered by the laws of the jurisdiction where the treatment is performed. A licensed Ophthalmic Dispenser, Chiropractor, Certified Psychologist or Psychological Associate is considered a Provider.

REASONABLE COSTS means costs that do not exceed negotiated schedules of payments which are accepted by Participating Providers, within a specific geographical area specified by the Plan Manager, as payment in full.

Definitions Continued

RECONSTRUCTIVE SURGERY means any Surgery (and all other associated expenses) which is:

1. incidental to or following surgical removal of all or less than all of a body part. The surgical removal must be done as the result of Injury or Sickness of the body part;
2. done because of a Sickness or a disorder of a normal bodily function; or
3. done to repair or lessen damage caused by an accident taking place on or after the effective date of this coverage for the Member.

RETIREE means a person who is in an eligible class as defined by Employer.

SEMI-PRIVATE ACCOMMODATIONS means a room with two or more beds in a Hospital, Skilled Nursing Facility or other Approved Health Care Facility or Approved Health Care Program. If a Participating Physician determines it is Medically Necessary, Semi-Private Accommodations also means private accommodations.

SICKNESS means a disturbance in function or structure of the body which causes physical signs or physical symptoms which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of the body. The term also includes pregnancy and medical complications of pregnancy.

SKILLED NURSING FACILITY means a facility which: (1) is licensed and operated in accordance with the laws of the state in which the facility is located; and (2) is approved by the Plan Manager to provide certain Health Services; and (3) is Medicare approved.

SOUND NATURAL 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.

SUMMARY PLAN DESCRIPTION means this document, which describes the services provided and to whom and how services are provided.

SURGERY means excision or incision of the skin or mucosal tissues, or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

TIMELY ENROLLEE means an Employee and/or an Employee's eligible Dependent who applies for medical coverage within 31 Days of the eligibility date.

TOTAL DISABILITY OR TOTALLY DISABLED means Your continuing inability, as the result of Injury or Sickness, to perform the material and substantial duties of any occupation for which You are suited by reason of education, training or experience. The term also means a Dependent's inability to engage in the normal activities of a person of like age. If a Dependent is employed, the term means the Dependent's inability to perform his or her job.

TRAUMA means an Injury to living tissue by an external physical force or chemical agent. Trauma does not include infections or psychic events. Trauma includes fractures, dislocations, sprains and strains, internal injuries, open wounds, superficial injuries, contusions and burns. The current International Classification of Diseases-9th Revision specifies these injuries with diagnosis codes 800.0-929.9 and 940.9-959.9.

Definitions Continued

URGENT CARE CLAIM means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or
2. in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
3. Generally, whether a claim is a claim involving urgent care will be determined by the Plan Manager. However, any claim that a Physician with knowledge of a Claimant's medical condition determines is a "claim involving urgent care" will be treated as a "claim involving urgent care."

YOU AND YOUR means You as the Employee or Retiree and any of Your covered Dependents, unless otherwise indicated.

ELIGIBILITY AND EFFECTIVE DATES

OPEN ENROLLMENT

Once annually You will have a choice of enrolling yourself and Your eligible Dependents in this Plan. You will be notified in advance when the Open Enrollment Period is to begin and how long it will last. If You decline coverage for yourself or Your Dependents at the time You are initially eligible for coverage, You will be able to enroll yourself and/or eligible Dependents during the Open Enrollment Period.

PRIMARY CARE PHYSICIAN

You must choose a Primary Care Physician for yourself and Your Dependents, if any, at the time of enrollment. If You fail to choose a Primary Care Physician, the Plan Manager will assign one to You and notify You of the assignment. You can change Your Primary Care Physician from time to time by notifying the Plan Manager that You are changing Your Primary Care Physician.

EMPLOYEE ELIGIBILITY

You are eligible for coverage if the following conditions are met:

1. You are an eligible full-time or part-time Employee as defined by the Employer, or a Retiree of the Employer who is under age sixty-five (65) and not Medicare eligible;

2. You reside, live or work in the service area;

3. You are entitled to participate in group coverage for current Employees or Retirees of the Employer, as determined by the Employer, and according to the terms of the Master Group Contract;

4. You are not a Medicare-eligible Employee who no longer has current Employee status (see Medicare Eligibles section).

Your eligibility date is Your date of hire, date of eligible family status change or January 1, following Open Enrollment, as applicable.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll via a telephone call to the iPeople Center or via web enrollment as acceptable to the Employer.

1. If Your completed enrollment is received by the Employer within 31 Days after Your eligibility date, Your coverage is effective on Your eligibility date, as applicable.

2. If Your completed enrollment is received by the Employer more than 31 Days after Your eligibility date, You are a Late Enrollee and You will not be eligible to apply for coverage under this Plan until the next annual Open Enrollment Period. Your coverage will be effective the first Day of the new Plan year.

ELIGIBILITY FOR YOUR DEPENDENTS

Each Dependent is eligible for coverage on:

1. The date the Employee or Retiree is eligible and enrolled for coverage, if he or she has Dependents who may be covered on that date; or

Eligibility and Effective Dates Continued

2. The date of the Employee's marriage for any Dependent acquired on that date; or

3. The date of birth of the Employee's natural-born Child; or

4. The date a Child is placed for adoption under the Employee's legal guardianship, or the date which the Employee incurs a legal obligation for total or partial support in anticipation of adoption; or

5. The date a covered Employee's Child is determined to be eligible as an alternate recipient under the terms of a Medical Child Support Order.

The Employee or Retiree must be enrolled in this plan in order for a Dependent to be enrolled in this plan. In any event, no person may be simultaneously covered as both an Employee or Retiree and a Dependent. If both parents are eligible for coverage, only one may enroll for Dependent coverage.

EFFECTIVE DATE FOR YOUR DEPENDENTS

1. If the Employee wishes to add a newborn Dependent or Dependent (other than a newborn) to the Plan, the Dependent can be added via a telephone call to the iPeople Center or via Web enrollment within 31 Days. If the completed enrollment is received within 31 Days after the Dependent's eligibility date, that Dependent is covered on the date he or she is eligible.

2. If the completed enrollment is received more than 31 Days after the Dependent's eligibility date, the Dependent is a Late Enrollee. The Dependent will not be eligible for coverage under this Plan until the next annual Open Enrollment Period. If You apply, Your Dependent's coverage will be effective the first Day of the new Plan year.

No Dependent's effective date will be prior to the covered Employee's effective date of coverage. A Dependent Child who becomes eligible for other group coverage through any employment is no longer eligible for coverage under this Plan. If Your Dependent Child becomes an eligible Employee of the Employer, he or she is no longer eligible as Your Dependent and must make application as an eligible Employee.

MEDICAL CHILD SUPPORT ORDERS

An individual who is a Child of a covered Employee shall be enrolled for coverage under the Plan in accordance with the direction of a Medical Child Support Order (MCSO) or a National Medical Support Notice (NMSN).

An MCSO is a state court order or judgment, including approval of a settlement agreement that: (a) provides for support of a covered Employee's Child; (b) provides for health care coverage for that Child; (c) is made under state domestic relations law (including a community property law); (d) relates to benefits under the Plan; and (e) is "qualified" in that it meets the technical requirements of ERISA or applicable state law. MCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to an MCSO that requires coverage under the Plan for the Dependent Child of a non-custodial parent who is (or will become) a Member by a domestic relations order that provides for health care coverage.

Procedures for determining the qualified status of MCSO are available at no cost upon request from the Plan Administrator.

Eligibility and Effective Dates Continued

CREDITABLE COVERAGE

Once You or Your Dependents obtain health plan coverage, You are entitled to use evidence of that coverage to reduce or eliminate any pre-existing condition limitation period that might otherwise be imposed when You become covered under a subsequent health plan. Evidence may include a certificate of prior Creditable Coverage. The length of any pre-existing condition limitation period under the subsequent health plan must be reduced by the number of days of Creditable Coverage.

SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS

Your coverage may remain in force for a period of time as determined by Your Employer for a layoff, approved leave of absence, Total Disability or military leave of absence. Please see Your Employer for details.

REINSTATEMENT OF COVERAGE FOLLOWING INACTIVE STATUS

If Your coverage under the Plan was terminated due to a period of service in the uniformed services covered under the Uniformed Services Employment and Reemployment Rights Act of 1994, Your coverage is effective immediately on the Day You return to work. Eligibility waiting periods will be imposed only to the extent they were applicable prior to the period of service in the uniformed services.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If You are granted a leave of absence (Leave) by the Employer as required by the Federal Family and Medical Leave Act, You may continue to be covered under the Plan for the duration of the Leave under the same conditions as other Employees who are in Active Status and covered by the Plan. If You choose to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date You return to Active Status immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if You had been continuously covered.

RETIREE COVERAGE

If You are a Retiree and not Medicare eligible You may continue coverage under the Plan until You become Medicare eligible. Please see Your Employer for more details.

SPECIAL ENROLLMENT

If You previously declined coverage under this Plan for Yourself or any eligible Dependents, due to the existence of other health coverage (including COBRA), and that coverage is now lost, this Plan permits You, Your Dependent spouse, and any eligible Dependents to be enrolled for medical benefits under this Plan due to any of the following qualifying events:

1. Loss of eligibility for the coverage due to any of the following:

    a. Legal separation;
    b. Divorce;
    c. Cessation of Dependent status (such as attaining the limiting age);
    d. Death;
    e. Termination of employment;
    f. Reduction in the number of hours of employment;
    g. Any loss of eligibility after a period that is measured by reference to any of the foregoing.

Eligibility and Effective Dates Continued

h. Meeting or exceeding a lifetime limit on all benefits;
i. Plan no longer offering benefits to a class of similarly situated individuals, which includes the Employee.

However, loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

2. Employer contributions towards the other coverage have been terminated. Employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.

3. COBRA coverage under the other plan has since been exhausted.

The previously listed qualifying events apply only if You stated in writing at the previous enrollment the other health coverage was the reason for declining enrollment, but only if Your Employer requires a written waiver of coverage which includes a warning of the penalties imposed on Late Enrollees.

If You are a covered Employee or an otherwise eligible Employee, who either did not enroll or did not enroll Dependents when eligible, You now have the opportunity to enroll Yourself and/or any previously eligible Dependents or any newly acquired Dependents when due to any of the following family status changes:

1. Marriage;
2. Birth; or
3. Adoption or placement for adoption.

You may elect coverage under this Plan provided enrollment is within 31 days from the qualifying event. You MUST provide proof that the qualifying event has occurred due to one of the reasons listed before coverage under this Plan will be effective. Coverage under this Plan will be effective the date of the qualifying event, unless otherwise specified in this section.

In the case of a Dependent's birth, enrollment is effective on the date of such birth.

In the case of a Dependent's adoption or placement for adoption, enrollment is effective on the date of such adoption or placement for adoption.

If You apply more than 31 days after a qualifying event, You are considered a Late Enrollee and will not be eligible for coverage under this Plan until the next annual Open Enrollment Period.

Please see Your Employer for more details.

Eligibility and Effective Dates Continued

EXTENDED COVERAGE FOR HANDICAPPED CHILDREN

Coverage of an unmarried Dependent Child who is incapable of self-support because of mental disability or physical handicap will be continued beyond the specified limiting age, provided that: (1) the Child became so incapacitated prior to attainment of the limiting age; (2) the Child is solely dependent upon You for support and maintenance; (3) proof of such incapacity and dependency satisfactory to the Plan Manager is furnished within 31 Days before the Child's attainment of the limiting age; and (4) payment of any required plan fee for the Child is continued. Coverage will be continued so long as the Child continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Plan.

Before granting this extension, the Plan Sponsor may require the Child to be examined, at our expense, by a Physician the Plan Manager designates. The Plan Sponsor may require satisfactory proof of the Child's continued incapacity and dependency, including medical examinations, at our expense, at reasonable intervals thereafter. However, such proof will not be required more often than once a year after the Child's attainment of the limiting age.

MEDICARE ELIGIBLES

INTEGRATION WITH MEDICARE

When an Employer employs 100 or more persons, the benefits of the Plan will be payable first for a Member who is under age 65 and eligible for Medicare. The benefits of Medicare will be payable second.

MEDICARE PART A means the Social Security program that provides Hospital insurance benefits.

MEDICARE PART B means the Social Security program that provides medical insurance benefits.

For the purposes of determining benefits payable for any Member who is eligible to enroll for Medicare Part B, but does not, the Plan Manager assumes the amount payable under Medicare Part B to be the amount the Member would have received if he or she enrolled for it. A Member is considered to be eligible for Medicare on the earliest date coverage under Medicare could become effective for him or her.

OPTIONS

Federal Law allows the Plan's actively working Covered Employees age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options:

OPTION 1- The benefits of the Plan will be payable first and the benefits of Medicare will be payable second.

OPTION 2- Medicare benefits only. The Member and his or her Dependents, if any, will not be covered by the Plan.

Each Covered Employee and each covered spouse will be provided with the choice to elect one of these options at least one month before the Covered Employee or the covered spouse becomes age 65. All new Covered Employees and newly covered spouses age 65 or older will also be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for a Covered Employee or Dependent who is under age 65.

Under Federal law, there are two categories of persons eligible for Medicare. The calculation and payments of benefits by the Plan differs for each category.

CATEGORY 1 Medicare Eligibles are actively working Covered Employees age 65 or older and their age 65 or older covered spouses, and age 65 or older covered spouses of actively working Covered Employees who are under age 65.

CATEGORY 2 Medicare Eligibles are any other Members entitled to Medicare, whether or not they enrolled for it. This category includes, but is not limited to, retired Covered Employees and their spouses or covered Dependents of a Covered Employee other than his or her spouse.

CALCULATION AND PAYMENT OF BENEFITS

For Members in Category 1, benefits are payable by the Plan without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For Members in Category 2, Medicare benefits are payable before any benefits are payable by the Plan. The benefits of the Plan will then be reduced by the full amount of all Medicare benefits the Member is entitled to receive, whether or not they were actually enrolled for Medicare.

TERMINATION OF COVERAGE

Employees: Termination of coverage is determined by Your Employer.

Dependents: Coverage terminates on the earliest of the following:

1. The date the Employee's or Retiree's coverage terminates;
2. The date of the Dependent's death;
3. The end of the calendar month the Dependent enters full-time military, naval or air service;
4. The end of the calendar month such Covered Person no longer meets the definition of Dependent;
5. The end of the calendar month the Employee or Retiree requests termination of coverage to be effective for their Dependents.
6. The end of the calendar month in which a survivor of an active Employee or Retiree remarries.

CONTINUATION OF MEDICAL BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was signed into law. This federal law applies to employers with 20 or more employees. The law requires that employers offer employees and/or their Dependents continuation of medical coverage at group rates in certain instances where there is a loss of group insurance coverage.

ELIGIBILITY

A qualified beneficiary under COBRA law means an Employee, Employee's spouse or Dependent Child covered by the Plan on the Day before a qualifying event. A qualified beneficiary under COBRA law also includes a Child born to the Employee during the coverage period or a Child placed for adoption with the Employee during the coverage period.

EMPLOYEE: An Employee covered by the Employer's Plan has the right to elect continuation coverage if coverage is lost due to one of the following qualifying events:

- Termination (for reasons other than gross misconduct) of the Employee's employment or reduction in the hours of Employee's employment; or
- Termination of retiree coverage when the former employer discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

SPOUSE: A spouse covered by the Employer's Plan has the right to elect continuation coverage if the group coverage is lost due to one of the following qualifying events:

- The death of the Employee;
- Termination of the Employee's employment (for reasons other than gross misconduct) or reduction of the Employee's hours of employment with the Employer;
- Divorce or legal separation from the Employee;
- The Employee becomes entitled to Medicare benefits; or
- Termination of a retiree spouse's coverage when the former employer discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

DEPENDENT CHILD: A Dependent Child covered by the Employer's Plan has the right to continuation coverage if group coverage is lost due to one of the following qualifying events:

- The death of the Employee parent;
- The termination of the Employee parent's employment (for reasons other than gross misconduct) or reduction in the Employee parent's hours of employment with the Employer;
- The Employee parent's divorce or legal separation;
- Ceasing to be a "Dependent Child" under the Plan;
- The Employee parent becomes entitled to Medicare benefits; or
- Termination of the retiree parent's coverage when the former employer discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

LOSS OF COVERAGE

Coverage is lost in connection with the foregoing qualified events, when a covered Employee, spouse or Dependent Child ceases to be covered under the same Plan terms and conditions as in effect immediately before the qualifying event (such as an increase in the premium or contribution that must be paid for Employee, spouse or Dependent Child coverage).

COBRA Continued

If coverage is reduced or eliminated in anticipation of an event (for example, an employer eliminating an Employee's coverage in anticipation of the termination of the Employee's employment, or an Employee eliminating the coverage of the Employee's spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

A loss of coverage need not occur immediately after the event, so long as it occurs before the end of the Maximum Coverage Period.

NOTICES AND ELECTION

The Plan provides that coverage terminates, for a spouse due to legal separation or divorce or for a Child when that Child loses Dependent status. Under the law, the Employee or qualified beneficiary has the responsibility to inform the Plan Administrator (see Plan Description Information) if one of the above events has occurred. The qualified beneficiary must give this notice within 60 Days after the event occurs. (For example, an ex-spouse should make sure that the Plan Administrator is notified of his or her divorce, whether or not his or her coverage was reduced or eliminated in anticipation of the event). When the Plan Administrator is notified that one of these events has happened, it is the Plan Administrator's responsibility to notify the COBRA Service Provider, who will in turn notify the qualified beneficiary of the right to elect continuation coverage.

For a qualified beneficiary who is determined under the Social Security Act to be disabled at any time during the first 60 Days of COBRA coverage, the continuation coverage period may be extended 11 additional months. The disability that extends the 18-month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. To be entitled to the extended coverage period, the disabled qualified beneficiary must provide notice to the COBRA Service Provider and Plan Administrator within the initial 18 month coverage period and within 60 Days after the date of the determination of disability under the Social Security Act. Failure to provide this notice will result in the loss of the right to extend the COBRA continuation period.

For termination of employment, reduction in work hours, the death of the Employee, the Employee becoming covered by Medicare or loss of retiree benefits due to bankruptcy, it is the Plan Administrator's responsibility to notify the COBRA Service Provider, who will in turn notify the qualified beneficiary of the right to elect continuation coverage.

Under the law, continuation coverage must be elected within 60 Days after Plan coverage ends, or if later, 60 Days after the date of the notice of the right to elect continuation coverage. If continuation coverage is not elected within the 60 Day period, the right to elect coverage under the Plan will end.

A covered Employee or the spouse of the covered Employee may elect continuation coverage for all covered Dependents, even if the covered Employee or spouse of the covered Employee or all covered Dependents are covered under another group health plan (as an Employee or otherwise) prior to the election. The covered Employee, his or her spouse and Dependent Child, however, each have an independent right to elect continuation coverage. Thus a spouse or Dependent Child may elect continuation coverage even if the covered Employee does not elect it.

Coverage will not be provided during the election period. However, if the individual makes a timely election, coverage will be provided from the date that coverage would otherwise have been lost. If coverage is waived before the end of the 60 Day election period and the waiver revoked before the end of the 60 Day election period, coverage will be effective on the date the election of coverage is sent to the COBRA Service Provider or Plan Administrator.

COBRA Continued

On August 6, 2002, The Trade Act of 2002 (TAA), was signed in to law. Workers whose employment is adversely affected by international trade (increased import or shift in production to another country) may become eligible to receive TAA. TAA provides a second 60-Day COBRA election period for those who become eligible for assistance under TAA. Pursuant to the Trade Act of 1974, an individual who is either an eligible TAA recipient or an eligible alternative TAA recipient and who did not elect continuation coverage during the 60-Day COBRA election period that was a direct consequence of the TAA-related loss of coverage, may elect continuation coverage during a 60-Day period that begins on the first Day of the month in which he or she is determined to be TAA-eligible individual, provided such election is made not later than 6 months after the date of the TAA-related loss of coverage. Any continuation coverage elected during the second election period will begin with the first Day of the second election period and not on the date on which coverage originally lapsed.

TAA created a new tax credit for certain individuals who became eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If You have questions about these new tax provisions, You may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

The Plan Administrator shall require documentation evidencing eligibility of TAA benefits. The Plan need not require every available document to establish evidence of TAA. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan.

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

- 18 months for an Employee and/or Dependent whose group coverage ended due to termination of the Employee's employment or reduction in hours of employment;
- 36 months for a spouse whose coverage ended due to the death of the Employee or retiree, divorce, or the Employee becoming entitled to Medicare at the time of the initial qualifying event;
- 36 months for a Dependent Child whose coverage ended due to the divorce of the Employee parent, the Employee becoming entitled to Medicare at the time of the initial qualifying event, the death of the Employee, or the Child ceasing to be a Dependent under the Plan;
- For the retiree, until the date of death of the retiree who is on continuation due to loss of coverage within one year before or one year after the Employer filed Chapter 11 bankruptcy.

DISABILITY

An 11-month extension of coverage may be available if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th Day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must provide notice of such determination prior to the end of the initial 18-month continuation period to be entitled to the additional 11 months of coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If a qualified beneficiary is determined by SSA to no longer be disabled, You must notify the Plan of that fact within 30 Days after SSA's determination.

COBRA Continued

SECOND QUALIFYING EVENT

An 18-month extension of coverage will be available to spouses and Dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying event may include the death of a covered Employee, divorce or separation from the covered Employee, the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a Dependent Child's ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 Days after the second qualifying event occurs if You want to extend Your continuation coverage.

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

Continuation coverage will terminate before the end of the maximum coverage period for any of the following reasons:

- The Employer no longer provides group health coverage to any of its Employees;
- The premium for continuation is not paid timely;
  The individual on continuation becomes covered under another group health plan (as an Employee or otherwise);
- The individual on continuation becomes entitled to Medicare benefits;
- If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than 30 Days after the determination;
- The occurrence of any event (e.g. submission of a fraudulent claim) permitting termination of coverage for cause under the Plan.

TYPE OF COVERAGE; PREMIUM PAYMENT

If continuation coverage is elected, the coverage must be identical to the coverage provided under the Employer's Plan to similarly situated non-COBRA beneficiaries. This means that if the coverage for similarly situated non-COBRA beneficiaries is modified, coverage for the individual on continuation will be modified.

The initial premium payment for continuation coverage is due by the 45th Day after coverage is elected. The initial premium includes charges back to the date the continuation coverage began. All other premiums are due on the first of the month for which the premium is paid, subject to a 31 Day grace period. The Employer or COBRA Service Provider must provide the individual with a quote of the total monthly premium.

Premium for continuation coverage may be increased, however, the premium may not be increased more than once in any determination period. The determination period is a 12 month period which is established by the Plan.

The monthly premium payment to the Plan for continuing coverage must be submitted directly to the Employer or COBRA Service Provider. This monthly premium may include the Employee's share and any portion previously paid by the Employer. The monthly premium must be a reasonable estimate of the cost of providing coverage under the Plan for similarly situated non-COBRA beneficiaries. The premium for COBRA continuation coverage may include a 2% administration charge. However, for qualified beneficiaries who are receiving up to 11 months additional coverage (beyond the first 18 months) due to disability extension (and not a second qualifying event), the premium for COBRA continuation coverage may be up to 150% of the applicable premium for the additional months. Qualified beneficiaries who do not take the additional 11 months of special coverage will pay up to 102% of the premium cost.

COBRA Continued

OTHER INFORMATION

Additional information regarding rights and obligations under the Plan and under federal law may be obtained by contacting the Plan Administrator or the COBRA Service Provider.

It is important for the Covered Person or qualified beneficiary to keep the COBRA Service Provider, Plan Administrator and Plan Manager informed of any changes in address.

PLAN CONTACT INFORMATION

iPeople Center
Cinergy Services, Inc.
139 E. Fourth St.
Cincinnati, OH 45202
Toll Free: 1-866-466-6947

Humana Insurance Company
Billing/Enrollment Department
101 E. Main Street
Louisville, KY 40201
Toll Free: 1-800-872-7207

CLAIMS PROCEDURES

SUBMITTING A CLAIM

This section describes what a Member (or his or her authorized representative) must do to file a claim for Plan benefits.

1. A claim must be filed with the Plan Manager and delivered to the Plan Manager, by mail, postage prepaid, by FAX or by e-mail. However, a submission to obtain pre-authorization may also be filed with the Plan Manager by telephone.
2. Claims must be submitted to the Plan Manager at the address indicated in the documents describing the Plan or Claimant's identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.
3. Also, claims submissions must be in a format acceptable to the Plan Manager and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of Protected Health Information and/or electronic claims standards will not be accepted by the Plan.
4. Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than 12 months after the date of loss, except if You were legally incapacitated. Plan benefits are only available for claims that are incurred by a Member during the period that he or she is covered under the Plan.
5. Claims submissions must be complete. They must contain, at a minimum:

    a. the name of the Member who incurred the Covered Expense;
    b. the name and address of the health care Provider;
    c. the diagnosis of the condition;
    d. the procedure or nature of the treatment;
    e. the date of and place where the procedure or treatment has been or will be provided;
    f. the amount billed and the amount of the Covered Expense not paid through coverage other than Plan coverage, as appropriate; and
    g. evidence that substantiates the nature, amount and timeliness of each Covered Expense in a format that is acceptable, according to industry standards, and in compliance with applicable law.

A general request for an interpretation of Plan provisions will not be considered to be a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the Plan, should be directed to the Plan Administrator.

Medical claims and correspondence should be mailed to:

Humana Claims Office
P.O. Box 14610
Lexington, KY 40512-4610

MISCELLANEOUS MEDICAL CHARGES

If You accumulate bills for medical items You purchase or rent yourself, send them to the Plan Manager at least once every three months during the year (quarterly). The receipts must include the patient name, name of item, date item purchased or rented and name of the Provider of service.

Claims Procedures Continued

PROCEDURAL DEFECTS

If a Pre-Service Claim submission is not made in accordance with the Plan's procedural requirements, the Plan Manager will notify the Claimant of the procedural deficiency and how it may be cured no later than within five (5) Days (or within 24 hours, in the case of an Urgent Care Claim) following the failure. A Post-Service Claim that is not submitted in accordance with these claims procedures will be returned to the submitter.

ASSIGNMENTS AND REPRESENTATIVES

A Member may assign his or her right to receive Plan benefits to a health care Provider only with the consent of the Plan Manager, in its sole discretion, except as may be required by applicable law. Assignments must be in writing. If a document is not sufficient to constitute an assignment, as determined by the Plan Manager, then the Plan will not consider an assignment to have been made. An assignment is not binding on the Plan until the Plan Manager receives and acknowledges in writing the original or copy of the assignment before payment of the benefit.

If benefits are assigned in accordance with the foregoing paragraph and a health care Provider submits claims on behalf of a Member, benefits will be paid to that health care Provider.

In addition, a Member may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The designation must be explicitly stated in writing and it must authorize disclosure of Protected Health Information with respect to the claim by the Plan, the Plan Manager and the authorized representative to one another. If a document is not sufficient to constitute a designation of an authorized representative, as determined by the Plan Manager, then the Plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to the Plan Manager in advance, or at the time an authorized representative commences a course of action on behalf of a Claimant. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the Claimant to the Claimant, which the Plan Manager may verify with the Claimant prior to recognizing the authorized representative status.

- In any event, a health care Provider with knowledge of a Claimant's medical condition acting in connection with an Urgent Care Claim will be recognized by the Plan as the Claimant's authorized representative.

Members should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of the Member, such as whether and how to appeal a claim denial.

CLAIMS DECISIONS

After submission of a claim by a Claimant, the Plan Manager will notify the Claimant within a reasonable time, as follows:

PRE-SERVICE CLAIMS

The Plan Manager will notify the Claimant of a favorable or adverse determination within a reasonable time appropriate to the medical circumstances but no later than 15 Days after receipt of the claim by the Plan.

Claims Procedures Continued

However, this period may be extended by an additional 15 Days, if the Plan Manager determines that the extension is necessary due to matters beyond the control of the Plan. The Plan Manager will notify the affected Claimant of the extension before the end of the initial 15-Day period, the circumstances requiring the extension and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the Claimant's failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The Claimant will have at least 45 Days from the date the notice is received to provide the specified information.

URGENT CARE CLAIMS

The Plan Manager will determine whether a claim is an Urgent Care Claim. This determination will be made on the basis of information furnished by or on behalf of a Claimant. In making this determination, the Plan Manager will exercise its judgment, with deference to the judgment of a Physician with knowledge of the Claimant's condition. Accordingly, the Plan Manager may require a Claimant to clarify the medical urgency and circumstances that support the Urgent Care Claim for expedited decision-making.

The Plan Manager will notify the Claimant of a favorable or adverse determination as soon as possible, taking into account the medical urgency particular to the Claimant's situation, but not later than 72 hours after receipt of the Urgent Care Claim by the Plan.

However, if a claim is submitted that does not provide sufficient information to determine whether, or to what extent, expenses are covered or payable under the Plan, notice will be provided by the Plan Manager as soon as possible, but not more than 24 hours after receipt of the Urgent Care Claim by the Plan. The notice will describe the specific information necessary to complete the claim.

- The Claimant will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information but not less than 48 hours.
- The Plan Manager will notify the Claimant of the Plan's Urgent Care Claim determination as soon as possible, but in no event more than 48 hours after the earlier of:

    1. The Plan's receipt of the specified information; or
    2. . The end of the period afforded the Claimant to provide the specified additional information.

CONCURRENT CARE DECISIONS

The Plan Manager will notify a Claimant of a Concurrent Care Decision that involves a reduction in or termination of benefits that have been pre-authorized. The Plan Manager will provide the notice sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of the adverse determination before the benefit is reduced or terminated.

A request by a Claimant to extend a course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided by the Plan Manager as soon as possible, taking into account the medical exigencies. The Plan Manager will notify a Claimant of the benefit determination, whether adverse or not within 24 hours after receipt of the claim by the Plan, provided that the claim is submitted to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Claims Procedures Continued

POST-SERVICE CLAIMS

The Plan Manager will notify the Claimant of a favorable or adverse determination within a reasonable time, but not later than 30 Days after receipt of the claim by the Plan.

However, this period may be extended by an additional 15 Days, if the Plan Manager determines that the extension is necessary due to matters beyond the control of the Plan. The Plan Manager will notify the affected Claimant of the extension before the end of the initial 30-Day period, the circumstances requiring the extension and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the Claimant's failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The Claimant will have at least 45 Days from the date the notice is received to provide the specified information. The Plan Manager will make a decision no later than 15 Days after the earlier of the date on which the information provided by the Claimant is received by the Plan or the expiration of the time allowed for submission of the additional information.

TIMES FOR DECISIONS

The periods of time for claims decisions presented above begin when a claim is received by the Plan, in accordance with these claims procedures.

PAYMENT OF CLAIMS

The Plan Manager will make direct payment to the Hospital, clinic or Physician's office unless the Plan Manager is advised in writing that You have already paid the bill. If You have paid the bill, please indicate on the original statement, "paid by Employee" and send it directly to the Plan Manager. You will receive a written explanation of the benefit determination. The Plan Manager reserves the right to request any information required to determine benefits or process a claim. You or the Provider of services will be contacted if additional information is needed to process Your claim.

When an Employee's Child is subject to a Medical Child Support Order (MCSO), the Plan Manager will make reimbursement of eligible expenses paid by You, the Child, the Child's non-Employee custodial parent or legal guardian, to that Child or the Child's custodial parent or legal guardian, or as provided in the MCSO.

Payment of benefits under this Plan will be made in accordance with an assignment of rights for You and Your Dependents as required under state Medicaid law.

Benefits payable on behalf of You or Your covered Dependent after death will be paid, at the Plan's option, to any Family Member(s) or Your estate.

The Plan Manager will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the Plan from further liability.

Any payment made by the Plan Manager in good faith will fully discharge it to the extent of such payment.

Payments due under the Plan will be paid upon receipt of written proof of loss.

Claims Procedures Continued

INITIAL DENIAL NOTICES

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted.

However, notices of adverse decisions involving Urgent Care Claims may be provided to a Claimant orally within the time frames noted for expedited Urgent Care Claim decisions. If oral notice is given, written notification will be provided to the Claimant no later than 3 Days after the oral notification.

A claims denial notice will state the specific reason or reasons for the adverse determination, the specific Plan provisions on which the determination is based and a description of the Plan's review procedures and associated timeline. The notice will also include a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary.

The notice will describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a Claimant free of charge upon request.

If the adverse determination is based on medical necessity, Experimental or Investigational or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse decision of an Urgent Care Claim, the notice will provide a description of the Plan's expedited review procedures applicable to such claims.

APPEALS OF ADVERSE DETERMINATIONS

A Claimant must appeal an adverse determination within 180 Days after receiving written notice of the denial (or partial denial). With the exception of Urgent Care Claims and Concurrent Care Decisions, the Plan uses a two level appeals process for all adverse determinations. The Plan Manager will make the determination on the first level of appeal. If the Claimant is dissatisfied with the decision on this first level of appeal, or if the Plan Manager fails to make a decision within the time frame indicated below, the Claimant may appeal to the Plan Administrator. Urgent Care Claims and Concurrent Care Decisions are subject to a single level appeal process only, with the Plan Manager making the determination.

A first level appeal must be made by a Claimant by means of written application, in person, or by mail (postage prepaid), addressed to:

Humana G&A
P.O. Box 14610
Lexington, KY 40512-4610

Claims Procedures Continued

A second level appeal must be made by a Claimant by means of written application, in person, or by mail (postage prepaid), addressed to:

Humana G&A
P.O. Box 14610
Lexington, KY 40512-4610

Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim.

A Claimant may review relevant documents and may submit issues and comments in writing. A Claimant on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or for research purposes, or not Medically Necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time Periods for Decisions on Appeal -- First Level

Appeals of claims denials will be decided and notice of the decision provided as follows:

Urgent Care Claims	As soon as possible, but not later than 72 hours after the Plan Manager receives the appeal request (if oral notification is given, written notification will follow in hard copy or electronic format within the next 3 Days).
Pre-Service Claims	Within a reasonable period, but not later than 15 Days after the Plan Manager receives the appeal request.
Post-Service Claims	Within a reasonable period but no later than 30 after Days after the Plan Manager receives the appeal request.
Concurrent Care Decisions	Within the time periods specified above, depending upon the type of claim involved.

Time Periods for Decisions on Appeal -- Second Level

Appeals of claims denials will be decided and notice of the decision provided as follows:

Pre-Service Claims	Within a reasonable period, but not later than 15 Days after the Plan Manager receives the appeal request.
Post-Service Claims	Within a reasonable period but no later than 30 Days after the Plan Manager receives the appeal request.

Claims Procedures Continued

APPEAL DENIAL NOTICES

Notice of a benefit determination on appeal will be provided to Claimants by mail, postage prepaid, by FAX, or by e-mail, as appropriate, within the time frames noted above.

A notice that a claim appeal has been denied will convey the specific reason or reasons for the adverse determination and the specific plan provisions on which the determination is based.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a Claimant free of charge upon request.

If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the event of a denial of an appealed claim, the Claimant on appeal will be entitled to receive, upon request and without charge, reasonable access to and copies of any document, record or other information:

1. Relied on in making the determination.
2. Submitted, considered or generated in the course of making the benefit determination.
3. That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations.
4. That constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment, without regard to whether the statement was relied on.

RIGHT TO REQUIRE MEDICAL EXAMS
(Applies only to medical Plans)

The Plan has the right to require that a medical exam be performed on any Claimant for whom a claim is pending as often as may be reasonably required. If the Plan requires a medical exam, it will be performed at the Plan's expense. The Plan also has a right to request an autopsy in the case of death, if state law so allows.

EXHAUSTION

Upon completion of the appeals process under this section, a Claimant will have exhausted his or her administrative remedies under the Plan. If the Plan Manager or Plan Administrator fails to complete a claim determination or appeal within the time limits set forth above, the Claimant may treat the claim or appeal as having been denied, and the Claimant may proceed to the next level in the review process.

LEGAL ACTIONS AND LIMITATIONS

A civil action may not be brought with respect to Plan benefits until all remedies under the Plan have been exhausted.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

CONTINUATION OF BENEFITS

Effective October 13, 1994 federal law requires that health plans must offer to continue coverage for Employees who are absent due to service in the uniformed services and/or their Dependents. Coverage may continue for up to 18 or 24 months after the date the Employee is first absent due to uniformed service.

ELIGIBILITY

An Employee is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, commissioned corps of the Public Health Service, or any other category of persons designated by the President of the United States of America in a time of war or national emergency. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and for the purpose of an examination to determine fitness for duty.

An Employee's Dependents who have coverage under the Plan immediately prior to the date of the Employee's covered absence are eligible to elect continuation under USERRA.

PREMIUM PAYMENT

If continuation of Plan coverage is elected under USERRA, the Employee or Dependent is responsible for payment of the applicable cost of coverage. If the Employee is absent for less than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences longer than 30 days, the cost may be up to 102% of the cost of coverage under the Plan. This includes the Employee's share and any portion previously paid by the Employer.

DURATION OF COVERAGE

Elected continuation coverage under USERRA will continue until the earlier of:

- 18 months beginning the first day of absence from employment due to service in the uniformed services for elections made prior to 12/10/04; or
- 24 months beginning the first day of absence from employment due to service in the uniformed services for elections beginning on or after 12/10/04; or
- The day after the *employee* fails to apply for or return to employment as required by USERRA, after completion of a period of service.

Under federal law, the period of coverage available under USERRA shall run concurrently with the COBRA period available to an Employee and/or eligible Dependents.

OTHER INFORMATION

Employees should contact their Employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the Employer of any changes in marital status, or a change of address.

COORDINATION OF BENEFITS PROVISIONS APPLICABLE TO ALL SERVICES

WHAT A COORDINATION OF BENEFITS PROVISION DOES

If a person is covered by this Plan and by any of the other plans described below, a coordination of benefits provision will be used when the amount of benefits payable by this Plan and the amount of benefits payable by any of the other plans for the same medical expenses would exceed the total amount of allowable expenses in a claim determination period. A coordination of benefits provision determines the order in which all plans pay their benefits and when, depending on the order of benefit determination, a plan may reduce its benefits so that not more than 100% of the total amount of allowable expenses are paid jointly by all plans.

Under this provision, a plan is defined as coverage of medical or dental expenses or services by any group insurance plan on an insured or uninsured basis; service plan contracts, group or individual practice or other pre-payment plans; or labor-management trusted plans, union welfare plans, employers organization plans or employee benefit organization plans. "Plan" does not include coverage under individual or franchise policies or contracts, an indemnity-type policy, an excess insurance policy, a specified disease or accident policy or a Medicare supplement policy. Each plan or part of a plan, which has the right to coordinate benefits, is considered to be a separate plan.

ORDER OF BENEFIT DETERMINATION

In order to administer this provision, it is first necessary to determine the order in which all of the plans pay their benefits. This order is shown below:

1. a plan which does not contain a coordination of benefits provision is considered to determine its benefits before a plan which does contain a coordination of benefits provision;
2. a plan which covers a person as an employee is considered to determine its benefits before a plan which covers a person as a dependent; and
3. a plan which covers a person as the dependent of a person whose month and day of birth (excluding the year of birth) occurs earlier in the Calendar Year is considered to determine its benefits before a plan which covers the person as the dependent of a person whose month and day of birth (excluding the year of birth) occurs later in the Calendar Year. If one of the plans does not have this "birthday rule" provision, then the plan without this provision determines the order in which benefits will be paid. In the case of divorced or legally separated parents, the order of payment is determined as shown below:

    a. if there is a court decree which establishes financial responsibility for a dependent child's health care expenses, the plan of the parent with that responsibility is considered to determine its benefits before the plan of the parent without the responsibility;
    b. if there is no such decree and the parent with custody of the child has not remarried, the plan which covers the child as a dependent of the parent with custody is considered to determine its benefits before the plan of the parent without custody; or
    c. if the parent with custody of the child has remarried, the plan which covers the child as a dependent of the parent with custody determines its benefits first, the plan which covers the child as a dependent of the step-parent determines its benefits second and the plan which covers the child as a dependent of the parent without custody determines its benefits third.

If the above rules fail to establish the order of payment, the plan that has covered the person for the longest time is considered to determine its benefits first. However, a person may be covered as an active employee by one plan and as a retired or laid-off person by another plan.

Coordination of Benefits Provisions Applicable To All Services Continued

In this case, if both plans contain a provision regarding retired or laid-off employees, the plan that covers the person as an active employee is considered to determine its benefits before the plan that covers the person as a retired or laid-off employee. If either one of the plans does not contain a provision for retired or laid-off employees, the order of benefit determination will be used to determine the order of payment by the plans.

HOW BENEFITS ARE COORDINATED

If, based on the order of benefit determination, the benefits of this Plan are payable first the benefits payable by the other plans are ignored when the Plan Manager determines the amount payable by this Plan. If this Plan's benefits are payable after those of any other plan, the Plan Manager adds up the benefits payable by each of the plans in the order in which they pay and compares the total benefits payable to the total amount of Allowable Expenses.

If this Plan's payments would result in benefits being paid that exceed total Allowable Expenses, this Plan's benefits are reduced. When coordination of benefits reduces the total amount otherwise payable in a claim determination period for a person covered by this Plan, each benefit that would have been payable in the absence of coordination is reduced in proportion. The reduced amounts are charged against any applicable benefit limit of this Plan. In no event will this Plan's payment be more than it would have been in the absence of other plans.

The Plan reserves the right to release to or obtain from any other health care plan, insurance company or other organization or person, any information which this Plan needs for the purpose of coordination of benefits.

When payment, which should have been made by this Plan based on the terms of this provision have been made by any other plan, the Plan has the right to pay to any organization making these payments an amount it considers to be warranted. Amounts paid in this manner are considered to be benefits paid by this Plan. After the Plan makes such payments it has no further liability.

When an overpayment has been made, the Plan has the right to recover that payment to the extent of the excess. The Plan may recover the overpayment from the person to whom it was made or from any other plan, insurance company or organization.

A Member must utilize a Participating Provider to be eligible for secondary benefits under this Plan.

REIMBURSEMENT/SUBROGATION

The Beneficiary agrees that by accepting and in return for the payment of Covered Expenses by the Plan in accordance with the terms of this Plan:

1. The Plan shall be repaid the full amount of the Covered Expenses it pays from any amount received from others for the bodily Injuries or losses which necessitated such Covered Expenses. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments.

2. The Plan's right to repayment is, and shall be, prior and superior to the right of any other person or entity, including the Beneficiary.

3. The right to recover amounts from others for the Injuries or losses which necessitate Covered Expenses is jointly owned by the Plan and the Beneficiary. The Plan is subrogated to the Beneficiary's rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse the Plan as prescribed above; the Plan has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which the Plan is subrogated are, and shall be, prior and superior to the rights of any other person or entity, including the Beneficiary.

4. The Beneficiary will cooperate with the Plan in any effort to recover from others for the bodily Injuries and losses which necessitate Covered Expense payments by the Plan. The Beneficiary will notify the Plan immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of the Plan. Neither the Plan nor the Beneficiary shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with the Plan Manager and when asked, assist the Plan Manager by:

- Authorizing the release of medical information including the names of all providers from whom You received medical attention;
- Obtaining medical information and/or records from any provider as requested by the Plan Manager;
- Providing information regarding the circumstances of Your Sickness or bodily Injury;
- Providing information about other insurance coverage and benefits, including information related to any bodily Injury or Sickness for which another party may be liable to pay compensation or benefits; and
- Providing information the Plan Manager requests to administer the Plan.

Failure to provide the necessary information will result in denial of any pending or subsequent claims, pertaining to a bodily Injury or Sickness for which the information is sought, until the necessary information is satisfactorily provided.

DUTY TO COOPERATE IN GOOD FAITH

You are obliged to cooperate with the Plan Manager in order to protect the Plan's recovery rights. Cooperation includes promptly notifying the Plan Manager that you may have a claim, providing the Plan Manager with relevant information, and signing and delivering such documents as the Plan Manager reasonably request to secure the Plan's recovery rights. You agree to obtain the Plan's consent before releasing any party from liability for payment of medical expenses. You agree to provide the Plan Manager with a copy of any summons, complaint or any other process serviced in any lawsuit in which you seek to recover compensation for your bodily injury or sickness and its treatment.

Reimbursement/Subrogation Continued

You will do whatever is necessary to enable the Plan Manager to enforce the Plan's recovery rights and will do nothing after loss to prejudice the Plan's recovery rights.

You agree that you will not attempt to avoid the Plan's recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

Failure of the covered person to provide the Plan Manager such notice or cooperation, or any action by the covered person resulting in prejudice to the Plan's rights will be a material breach of this Plan and will result in the covered person being personally responsible to make repayment. In such an event, the Plan may deduct from any pending or subsequent claim made under this Plan any amounts the covered person owes the Plan until such time as cooperation is provided and the prejudice ceases.

GENERAL PROVISIONS

The following provisions are to protect Your legal rights and the legal rights of the Plan.

RELATIONSHIP BETWEEN PARTIES

The relationship between the Plan Manager, Participating Providers and the Plan Sponsor is a contractual relationship between independent contractors. Participating Providers and Groups are not the Plan Manager's agents or employees nor is the Plan Manager or any of the Plan Manager's employees an agent or employee of Participating Providers or the Group.

The relationship between a Participating Provider and any Member is that of Provider and patient. The Participating Provider is solely responsible for the medical services provided to any Member.

The relationship between the Group and any Member is that of Employer and Employee or Dependent.

CONTESTABILITY

The Plan has the right to contest the validity of Your coverage under the Plan at any time.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

1. Made in error; or

2. Made to You or any party on Your behalf where the Plan determines the payment to You or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against You if the Plan has paid You or any other party on Your behalf.

WORKERS' COMPENSATION NOT AFFECTED

The Plan is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease Act or Law.

WORKERS' COMPENSATION

If benefits are paid by the Plan and the Plan determines You received Workers' Compensation for the same incident, the Plan has the right to recover as described under the Reimbursement/Subrogation provision. The Plan will exercise its right to recover against You even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that bodily Injury or Sickness was sustained in the course of or resulted from Your employment;

3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by You or the Workers' Compensation carrier;

4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

General Provisions Continued

You hereby agree that, in consideration for the coverage provided by the Plan, You will notify the Plan Manager of any Workers' Compensation claim You make, and that You agree to reimburse the Plan as described above.

MEDICAID

This Plan will not take into account the fact that an Employee or Dependent is eligible for medical assistance or Medicaid under state law with respect to enrollment, determining eligibility for benefits, or paying claims.

If payment for Medicaid benefits has been made under a state Medicaid plan for which payment would otherwise be due under this Plan, payment of benefits under this Plan will be made in accordance with a state law which provides that the state has acquired the rights with respect to a covered Employee to the benefits payment.

CONSTRUCTION OF PLAN TERMS

The Plan has the sole right to construe and prescribe the meaning, scope and application of each and all of the terms of the Plan, including, without limitation, the benefits provided thereunder, the obligations of the beneficiary and the recovery rights of the Plan; such construction and prescription by the Plan shall be final and uncontestable.

PRIVACY OF PROTECTED HEALTH INFORMATION

In order for the Plan to operate, it may be necessary from time to time for health care professionals, the Plan Administrator, individuals who perform Plan-related functions under the auspices of the Plan Administrator, the Plan Manager and other service providers that have been engaged to assist the Plan in discharging its obligations with respect to delivery of benefits, to have access to what is referred to as Protected Health Information.

A Covered Person will be deemed to have consented to use of Protected Health Information about him or her by virtue of enrollment in the Plan. Any individual who may not have intended to provide this consent and who does not so consent must contact the Plan Administrator prior to filing any claim for Plan benefits, as coverage under the Plan is contingent upon consent.

Individually identifiable health information will only be used or disclosed for purposes of Plan operation or benefits delivery. In that regard, only the minimum necessary disclosure will be allowed. The Plan Administrator, Plan Manager, and other entities given access to Protected Health Information, as permitted by applicable law, will safeguard Protected Health Information to ensure that the information is not improperly disclosed.

Disclosure of Protected Health Information is improper if it is not allowed by law or if it is made for any purpose other than Plan operation or benefits delivery. Disclosure for Plan purposes to persons authorized to receive Protected Health Information may be proper, so long as the disclosure is allowed by law and appropriate under the circumstances. Improper disclosure includes disclosure to the Employer for employment purposes, employee representatives, consultants, attorneys, relatives, etc. who have not executed appropriate agreements effective to authorize such disclosure.

The Plan Manager will afford access to Protected Health Information in its possession only as necessary to discharge its obligations as a service provider, within the restrictions noted above. However, Plan records that include Protected Health Information are the property of the Plan. Information received by the Plan Manager is information received on behalf of the Plan.

The Plan Manager will afford access to Protected Health Information as reasonably directed in writing by the Plan Administrator, which shall only be made with due regard for confidentiality. In that regard, the Plan Manager has been directed that disclosure of Protected Health Information may be made to the following parties:

Attn: Manager of iPeople Center
Cinergy Services, Inc.
139 E. Fourth St.
Cincinnati, OH 45202

Attn: HR Specialists of iPeople Center
Cinergy Services, Inc.
139 E. Fourth St.
Cincinnati, OH 45202

Attn: Health Care Group
Cinergy Services, Inc.
139 E. Fourth St.
Cincinnati, OH 45202

Individuals who have access to Protected Health Information in connection with their performance of Plan-related functions under the auspices of the Plan Administrator will be trained in these privacy policies and relevant procedures prior to being granted any access to Protected Health Information. The Plan Manager and other Plan service providers will be required to safeguard Protected Health Information against improper disclosure through contractual arrangements.

Privacy of Protected Health Information Continued

In addition, You should know that the Employer / Plan Sponsor may legally have access, on an as-needed basis, to limited health information for the purpose of determining Plan costs, contributions, Plan design, and whether Plan modifications are warranted. In addition, federal regulators such as the Department of Health and Human Services and the Department of Labor may legally require access to Protected Health Information to police federal legal requirements about privacy.

Covered Persons may have access to Protected Health Information about them that is in the possession of the Plan, and they may make changes to correct errors. Covered Persons are also entitled to an accounting of all disclosures that may be made by any person who acquires access to Protected Health Information concerning them and uses it other than for Plan operation or benefits delivery. In this regard, please contact the Plan Administrator.

Covered Persons are urged to contact the originating health care professional with respect to medical information that may have been acquired from them, as those items of information are relevant to medical care and treatment. And finally, Covered Persons may consent to disclosure of Protected Health Information, as they please.

HEALTH SERVICES AGREEMENT

SCHEDULE OF SERVICES PROVIDED BY PARTICIPATING PROVIDERS

Each Member is entitled to receive the covered Health Services and benefits described below. All such Health Services:

(1) Must be Medically Necessary unless specified otherwise;

(2) Are subject to the exclusions and limitations described elsewhere in this agreement; and

(3) Are subject to any stated Copayment amounts.

Services rendered by Non-Participating Providers are not covered, except as specifically indicated in the "Referral Health Services Rendered by Non-Participating Providers" and "Emergency Coverage at Non-Participating Providers" sections of this Summary Plan Description.

Services are deemed to be received on the date a covered service is performed or furnished.

A Member may request the transfer of his or her medical care to another Primary Care Physician whose practice is open to enrollment of additional patients. The Member may request such a transfer as often as it is medically appropriate. The transfer of care to the newly selected Primary Care Physician will be made within 24 hours, if at all possible, and be effective on the first Day of the month if the Plan Manager receives the request by the last working Day of the previous month. In the event transfer is not accomplished within 24 hours, the Member will receive a credit for the office visit Copayment amount applicable to the first visit to the new Primary Care Physician.

Lifetime maximum: Unlimited

A. Precertification

Medical Management is a Utilization/Case Management Program provided by the Plan Manager.

The Medical Management team will provide Precertification as required by Your Plan. Medical Management recommends calling as soon as possible to receive proper Precertification. Refer to Your ID card for the phone number to call for Precertification.

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	PENALTY
Inpatient Hospitalization	The Plan Manager must be notified prior to Admission. If the Admission is on an emergency basis, the Plan Manager must be notified within 48 hours or the first business Day following Admission.	If the Admission is not precertified, benefits for both the Physician and Hospital are not covered.
Inpatient Mental Disorder, Chemical Dependence or Alcoholism	The Plan Manager must be notified prior to Admission. If the Admission is on an emergency basis, the Plan Manager must be notified within 48 hours or the first business Day following Admission.	If the Admission is not precertified, benefits for both the Physician and Hospital are not covered.
Outpatient Mental Disorder, Chemical Dependence or Alcoholism	The Plan Manager must be notified prior to services being rendered.	If Outpatient Mental Disorder, Chemical Dependence or Alcoholism is not precertified, it is not covered.
Skilled Nursing Facility	The Plan Manager must be notified prior to services being rendered.	If the Skilled Nursing Facility Confinement is not precertified, it is not covered.
Home Health Care	The Plan Manager must be notified prior to services being rendered.	If Home Health Care is not precertified, it is not covered.
Hospice Care	The Plan Manager must be notified prior to services being rendered.	If Hospice Care is not precertified, it is not covered.
Dental Injuries and Oral Surgery	The Plan Manager must be notified prior to services being rendered.	If a dental Injury or Oral Surgery is not precertified, it is not covered.

B. Basic Primary Care Physician's Services

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	MEMBER'S COPAYMENT
Services received in the Physician's office (other than routine services – please see below for routine care benefits)	Must be for the diagnosis, care or treatment of a Sickness or Injury.	$20 per visit
Visits while the Member is confined in a Hospital	Only while services are being provided under Subsection D (Room, board, general nursing care and Medically Necessary special diets) of this schedule, including, but not limited to, the initial examination of a newborn Child.	None
Emergency room visits	Must be for the diagnosis, care or treatment of a Sickness or Injury. Subject to the terms and conditions outlined in the Emergency Coverage at Non-Participating Providers provision and the Eligible Expenses For Emergency Medical Conditions provision.	$75 per visit (waived if admitted)
Allergy testing, serum and injections		None
Injections of drugs or medicines	Must be for the treatment of a Sickness or Injury; does not include allergy treatments or immunizations covered under Subsection B (allergy testing, serum and injections or immunizations) of this schedule.	None
Immunizations	Does not apply to immunizations given for, or in connection with, travel.	None
Diagnostic x-ray and laboratory		$50 for CAT/PET scans and MRI
Routine Child care exam		$20 per visit
Adult routine care exam	Annual exams must be appropriate with regard to Member's age, sex and health status, as determined by the Plan Manager.	$20 per visit
Routine x-ray and laboratory		$50 for CAT/PET scans and MRI
Routine vision exams (including refraction and tonometry)	Limited to one per Calendar Year.	$20 per visit

B. Basic Primary Care Physician's Services (continued)

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	MEMBER'S COPAYMENT
Routine hearing: Exams Testing	Limited to one per Calendar Year.	 $20 per visit None
Routine mammogram	Limited to one mammogram for women age 35 through 39, one mammogram every two years for women age 40 through 49, and one mammogram per Calendar Year for women age 50 and over.	None
Routine pap smears	Limited to one per Calendar Year.	$20 per visit for the exam
Prostate antigen testing	Limited to one per Calendar Year.	None
Surgery, anesthesia and its administration	If multiple surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the Reasonable Cost for the primary procedure and 50% of the Reasonable Cost for subsequent procedures when performed independently. No benefits will be payable for incidental procedures.	None

C. Basic Participating Physician's Services (Does Not Include Primary Care Physician's Services)

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	MEMBER'S COPAYMENT
Services received in the Physician's office	Must be for the diagnosis, care or treatment of a Sickness or Injury.	$20 per visit
Visits while the Member is confined in a Hospital	Only while services are being provided under Subsection D (Room, board, general nursing care and Medically Necessary special diets) of this schedule, including, but not limited to, the initial examination of a newborn Child.	None
Emergency room visits	Must be for the diagnosis, care or treatment of a Sickness or Injury. Subject to the terms and conditions outlined in the Emergency Coverage at Non-Participating Providers provision and the Eligible Expenses For Emergency Medical Conditions provision.	$75 per visit (waived if admitted)

C. Basic Participating Physician's Services (Does Not Include Primary Care Physician's Services) (Continued)

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	MEMBER'S COPAYMENT
Allergy testing, serum and injections		None
Injections of drugs or medicines	Must be for the treatment of a Sickness or Injury; does not include allergy treatments or immunizations covered under Subsection B (allergy testing, serum and injections or immunizations) of this schedule.	None
Routine vision exams (including refraction and tonometry)	Limited to one per Calendar Year.	$20 per visit
Routine hearing: Exams Testing	Limited to one per Calendar Year.	 $20 per visit None
Diagnostic x-ray and laboratory, Pathologist and Radiologist		$50 for CAT/PET scans and MRI
Routine mammogram	Limited to one mammogram for women age 35 through 39, one mammogram every two years for women age 40 through 49, and one mammogram per Calendar Year for women age 50 and over.	None
Routine pap smears	Limited to one per Calendar Year.	$20 per visit for the exam
Prostate antigen testing	Limited to one per Calendar Year.	None
Surgery, anesthesia and its administration	Includes surgical assistance, covered at 25% of the primary surgeon's fee. If multiple surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the Reasonable Cost for the primary procedure and 50% of the Reasonable Cost for subsequent procedures when performed independently. No benefits will be payable for incidental procedures.	None
Second surgical opinion from a consulting participating Physician	Consulting Participating Physician must personally examine the Member.	$20 per visit No copayment applies if a second surgical opinion is required by Humana.

D. Hospital Services

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	MEMBER'S COPAYMENT
Room, board, general nursing care and Medically Necessary special diets	Semi-private Accommodations for 365 Days per Confinement. Private room and intensive care accommodations covered if ordered by the Member's Primary Care Physician. Precertification is required.	$100 per Admission, limited to $200 per Covered Person and $300 per family per Calendar Year.
Ancillary services while confined, including the administration of blood and blood components	Only while services are being provided under Subsection D (Room, board, general nursing care and Medically Necessary special diets) of this schedule. Does not cover the cost of blood or blood components if they are replaced.	None
Emergency room services (emergency Sickness or Injury)	Subject to the terms and conditions outlined in the Emergency Coverage at Non-Participating Providers provision and the Eligible Expenses for Emergency Medical Conditions provision. Emergency Room services for a non-emergency Sickness are not covered.	$75 per visit (waived if admitted)
Pre-admission tests	Must be ordered by a Participating Physician.	None
Outpatient Surgery performed in a Hospital	If multiple surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the Reasonable Cost for the primary procedure and 50% of the Reasonable Cost for subsequent procedures when performed independently. No benefits will be payable for incidental procedures.	$50 per visit
Other Hospital outpatient services		$50 for CAT/PET scans and MRI

E. Other Medical and Physician's Services, If Not Provided Under Any Other Subsection of the Group Plan

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	MEMBER'S COPAYMENT
Chemotherapy, Radiation Therapy and Respiratory Therapy		None
Cardiac Rehabilitation (limited to phases I and II)		Phase I – None Phase II – 20%
Diagnostic procedures, tests or x-ray exams, microscopic tests, or any lab test or analysis made for diagnosis or treatment, including breast cancer screening		$50 for CAT/PET scans and MRI
Speech, Physical and Occupational therapy	Speech, physical and occupational therapy are limited to a combined maximum of 70 visits per Calendar Year.	$20 per visit (only one Copayment will be taken per visit)
Oxygen	Includes the use of equipment for its administration.	None
Professional ambulance service		None when billed in conjunction with an emergency or when approved in advance by the Plan.
Private duty nursing services provided on an inpatient or an outpatient basis	The Participating Physician must certify in writing that the nursing services are needed.	None
Outpatient care and treatment in a Free-standing Surgical Facility/Ambulatory Surgical Center		$50 per visit
Urgent care facility		$20 per visit
Diabetic services: a) Diabetes Self-management Training b) Diabetes Equipment c) Diabetes Supplies		 $20 per visit Same as Durable Medical Equipment Copayment Not covered

E. Other Medical and Physician's Services, If Not Provided Under Any Other Subsection of the Group Plan (Continued)

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	MEMBER'S COPAYMENT
Durable Medical Equipment, Infusion Pumps for the treatment of Diabetes, Prosthetics, Prosthetic Wig, Orthotics and Surgical/Medical Supplies	Durable Medical Equipment must be certified in writing by a Participating Physician as Medically Necessary. If the cost of renting the equipment is more than its purchase price, only the cost of the purchase is considered a covered service. The equipment must be provided by a Participating Provider if one is available. The first prosthetic wig following cancer treatment is covered to a maximum of 1 wig and $250 per lifetime.	Physician's office: None All other places of treatment: 20%
Chiropractic Care (exams, x-ray and laboratory, manipulations and therapy)	Limited to 15 visits per Calendar Year. Routine Maintenance Care is not covered.	$20 per visit (only one Copayment will be taken per visit) $50 for CAT/PET scans and MRI
Temporomandibular Joint Dysfunction (TMJ): Exams/Therapy Laboratory and X-ray Surgery Splint/Appliances	 Limited to one bite splint per lifetime.	 $20 per visit None None Same as Durable Medical Equipment benefit

F. Home Health Care Services

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	MEMBER'S COPAYMENT
Nursing care, physical, occupational, respiratory and speech therapy, medical social work, nutrition services and home health aide services	Nursing care must be by, or under the supervision, of a registered nurse, licensed practical nurse or a licensed vocational nurse. Precertification is required.	None
Medical appliances and equipment, laboratory services and special meals		None

G. Skilled Nursing Facility Services

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	MEMBER'S COPAYMENT
Room, board, services, supplies and routine care	Precertification is required.	None
Visits from a Physician during Confinement		None

H. Hospice Care Services

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	MEMBER'S COPAYMENT
Inpatient respite care	Services are subject to the same conditions and limitations as Medicare benefits and must be described in a Hospice Care Program which has been submitted to the Plan Manager in writing and is approved by the Plan Manager. Precertification is required.	None
Drugs dispensed by hospice for pain management and symptom relief	Same as above	None
All other covered services	Same as above. Bereavement is not covered.	None

I. Maternity/Family Planning Services

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	MEMBER'S COPAYMENT
Hospital room and board	Semi-private Accommodations: a) for inpatient care for a mother and her newly born Child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by Cesarean section; or b) For a shorter length of stay, with the consent of the mother, if the Primary Care Physician determines that the mother and the newborn meet medical stability criteria and the Plan authorizes an initial postpartum Home Health Care visit which includes the collection of an adequate sample for hereditary and metabolic newborn screening.	None
Hospital services and supplies	Only while services are being provided under Subsection I (Hospital room and board) of this schedule.	None

I. Maternity/Family Planning Services (Continued)

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	MEMBER'S COPAYMENT
Obstetrical services of a Physician	Includes the cost and administration of anesthetics.	None
Pre-natal and post natal care	In a Physician's office, includes Medically Necessary testing.	$20 for the initial visit only; covered at 100% thereafter
Newborn services		None
Birthing centers		None
Infertility Services (Counseling and Treatment) and Artificial Means of Achieving Pregnancy	Excludes In vitro fertilization, Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), donor eggs transfer, Intrasytoplasmic sperm injection and any other artificial means of achieving pregnancy.	20%
Birth control devices, injections, implant systems and the removal of implant systems		20%
Tubal ligations and vasectomies		None
Elective abortions	Covered only if the pregnancy is a life-threatening physical condition of the covered female person.	None

J. Mental and Nervous Disorder, Alcoholism and Drug Dependency Services
(The following Health Services are covered only when provided by or authorized in advance by Your Primary Care Physician. Referrals to Participating Psychiatrist's Office, a Participating Hospital or other Approved Health Care Program shall in all cases be at the sole discretion of the Plan or its Psychiatric Designee.)

Inpatient and Outpatient Mental and Nervous Disorders Services:

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	MEMBER'S COPAYMENT
Inpatient/Partial Hospitalization Services	Services while the Covered Person is confined as a bed-patient in a Participating Hospital or other Approved Health Care Program, including day treatment. Member must be under supervision of a Participating Physician. Limited to 30 Days per Calendar Year. Two Days of partial hospitalization equals one inpatient Day. Precertification is required.	$100 per visit
Outpatient Services (individual therapy)	Coverage up to a maximum of 20 visits per Calendar Year. Precertification is required. Group therapy is not covered.	$20 per visit

J. Mental and Nervous Disorder, Alcoholism and Drug Dependency Services (Continued)

Inpatient/Outpatient Alcoholism and Drug Dependency Services:

DESCRIPTION OF SERVICES	SPECIAL PROVISIONS	MEMBER'S COPAYMENT
Inpatient/Partial Hospitalization Rehabilitation Services	Services while the Covered Person is confined as a bed-patient in a Participating Hospital or other Approved Health Care Program, including day treatment. Member must be under supervision of a Participating Physician. Limited to one complete program per lifetime. If the program is not completed, services will be payable under the Detoxification Treatment benefit. Precertification is required.	$100 per visit
Outpatient Rehabilitation Services (individual therapy)	Limited to one complete program per lifetime. If the program is not completed, services will be payable under the Detoxification Treatment benefit. Precertification is required. Group therapy is not covered.	None
Inpatient Detoxification Treatment	Services while the Covered Person is confined as a bed-patient in a Participating Hospital or other Approved Health Care Program, including day treatment. Member must be under supervision of a Participating Physician. Precertification is required.	50%
Outpatient Detoxification Treatment	Precertification is required.	50%

COPAYMENT LIMITS

After a Member makes Copayments equal to $750 in a Calendar Year, no further Copayments must be made for the remainder of that Calendar Year only. After a family makes Copayments equal to $1,500 in a Calendar Year, no further Copayments must be made by Members of that family for the remainder of that Calendar Year only. These Copayment limits apply to Copayments made under all subsections of the Health Services Agreement, except Durable Medical Equipment and Prosthetics. The Member is responsible for demonstration of the amount of Copayments made. The Member may call our Customer Service Department for information on Copayment limits.

PARTICIPATING PROVIDER AND FACILITY DIRECTORY

The Plan Administrator will automatically provide, without charge, information to You about how You can access a directory of Participating Providers, appropriate to Your service area. The Participating Provider directory will be available either in hard copy as a separate document, or in electronic format. Because health care Providers enter and exit networks unpredictably, the Plan Manager can be contacted for network Provider verification.

REFERRAL HEALTH SERVICES RENDERED BY NON-PARTICIPATING PROVIDERS

In the event that specific Health Services cannot be provided by or through a Participating Provider, a Member is entitled to coverage for Medically Necessary Health Services obtained through Non-Participating Providers. All such Health services must be ordered or approved by the Member's Primary Care Physician. They are subject to all of the terms, conditions, limitations and exclusions of the Summary Plan Description.

EMERGENCY COVERAGE AT NON-PARTICIPATING PROVIDERS

The Plan will pay covered Health Services and benefits for an Emergency Medical Condition rendered by a Non-Participating Provider to a Member, subject to the terms, conditions, limitations and exclusions of the Summary Plan Description.

The required Emergency Medical Condition and follow-up care, if applicable, must be: (1) of such immediate nature that the Member's health may be seriously jeopardized if taken to a Participating Hospital or other facility where the services or the Member's Primary Care Physician or a Participating Physician would be available; or (2) provided under circumstances under which the Member is unable, due to his or her condition, to request treatment at a location where the services of the Member's Primary Care Physician or a Participating Physician would be available.

The Member must notify the Plan Manager within 48 hours after emergency services are initially provided by a Non-Participating Provider or as soon thereafter as is reasonably possible. Full details of the Emergency Medical Condition received shall be made available by the Member at the request of the Plan.

If the Member is hospitalized, the Member at the Plan's election may be transferred to a Participating Hospital as soon as it is medically appropriate in the opinion of the attending Physician.

ELIGIBLE EXPENSES FOR EMERGENCY MEDICAL CONDITIONS

Eligible expenses for Emergency Medical Conditions are the Reasonable Costs for the Health Services described in this contract, provided during the course of the emergency, and when deemed Medically Necessary by the attending Physician. The Health Services must be provided by or under the direction of a Physician and are subject to the exclusions and other provisions of the Plan.

Benefits are not provided for the use of an emergency room except for treatment of Emergency Medical Conditions, emergency screening and stabilization. All follow up or continued care services must be authorized by Your Primary Care Physician.

If the Non-Participating Provider determines that the Sickness or Injury was not serious enough to warrant coverage as an Emergency Medical Condition, the Member will be responsible for any Reasonable Costs incurred for any treatment beyond the medical screening and stabilization.

COVERAGE OF OUT-OF-AREA DEPENDENTS

Dependents who reside outside of the service area because they are enrolled in an educational institution on a full-time basis may be covered under the Plan. Outside the service area, only Emergency and Urgent Care Medical Conditions are covered. Payment of those services will be made in accordance with the Emergency Coverage at Non-Participating Providers section of this contract. Non-emergency services will be covered only if rendered by Participating Providers.

When an out-of-area Member enters the service area on a temporary basis, coverage will be provided under the same terms and conditions as Members who reside in the service area. If the Dependent moves into the service area, or if the service area is changed to include the Dependent's residence, the Dependent will immediately cease to be considered an out-of-area Member.

ORGAN TRANSPLANT SERVICES

The Plan will pay benefits for the expense of a Covered Organ Transplant as defined below, incurred by a Member for an organ transplant approved in advance by the Plan Manager using a facility and Physician(s) both approved in advance by the Plan Manager, subject to those terms, conditions and limitations described below and contained in the Plan. Please contact the Plan Manager's Transplant Management Department when in need of these services.

Covered Organ Transplant means only the services, care and treatment received for or in connection with the pre-approved transplant of the organs identified hereafter, which are determined by the Plan Manager to be Medically Necessary Services and which are not Experimental or Investigational. The Covered Organ Transplant includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services and treatment of complications after transplantation of the following organs or procedures only:

1. heart;
2. lung(s);
3. heart-lung;
4. liver;
5. kidney;
6. bone marrow;
7. intestine;
8. simultaneous pancreas/kidney;
9. pancreas following kidney;
10. pancreas;
11. any organ not listed above required by federal law.

The term **Bone Marrow** identified in the foregoing Covered Organ Transplant definition refers to the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppressive chemotherapy. Such cells may be derived from bone marrow, circulating blood or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving a Covered Organ Transplant of Bone Marrow, the term **Bone Marrow** includes the harvesting, the transplantation and the chemotherapy components. Storage of cord blood and stem cells will not be covered unless as an integral part of a Covered Organ Transplant of Bone Marrow approved by the Plan Manager.

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular Plan benefits and are subject to other applicable provisions of the Plan.

For a Covered Organ Transplant to be considered fully approved, prior written approval from the Plan Manager is required in advance of the Covered Organ Transplant. You or Your Primary Care Physician must notify the Plan Manager in advance of Your need for an initial evaluation for the Covered Organ Transplant in order for the Plan Manager to determine if the Covered Organ Transplant will be covered. For approval of the Covered Organ Transplant itself, the Plan Manager must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

EXCLUSIONS

No benefits are payable for or in connection with a Covered Organ Transplant if:

1. It is Experimental or Investigational as defined elsewhere in the Plan;
2. The Plan Manager is not contacted for authorization prior to referral for evaluation of the Covered Organ Transplant, unless such authorization is waived by the Plan Manager;
3. The Plan Manager did not approve coverage for the Covered Organ Transplant, based on the Plan Manager's established criteria;

Organ Transplant Services Continued

4. The Covered Organ Transplant or Covered Organ Transplant evaluation is performed at a facility or by a Physician that is not designated by the Plan Manager as an approved transplant facility or Physician;
5. Expenses are eligible to be paid under any private or public research fund, government program except Medicaid or another funding program, whether or not such funding was applied for or received;
6. The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the Plan;
7. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by the Plan;
8. A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs and complications of such transplant; or
9. The Member for whom a Covered Organ Transplant is requested has not met pre-transplant criteria as established by the Plan Manager.

Once the Covered Organ Transplant is approved, the Plan Manager will advise the Member's Primary Care Physician of those facilities and Physicians that have been approved for the type of Covered Organ Transplant involved. Benefits are payable only if the pre-transplant services, the Covered Organ Transplant and post-discharge services are performed at an approved facility and by approved Physicians.

COVERED SERVICES

For approved Covered Organ Transplants, and all related complications, the Plan will cover only the following expenses:

1. Hospital expenses and Physician's expenses, under the same terms and conditions as the Plan will cover care and treatment for any other covered Injury or Illness under the Plan;
2. Organ acquisition and donor costs. However, donor costs are not payable under the Plan if they are payable in whole or in part by any other Group Plan, insurance company, organization or person other than the donor's family or estate; and
3. Direct, non-medical costs for the Member receiving the Covered Organ Transplant will be paid for: (a) transportation to and from the approved facility where the Covered Organ Transplant is performed; and (b) temporary lodging at a prearranged location when requested by the approved transplant facility and approved by the Plan Manager. These direct, non-medical costs are only available if the Member lives more than 100 miles from the approved facility.
4. Direct, non-medical costs for one member of the Member's immediate family (two members if the patient is under age 18 years) will be paid for: (a) transportation to and from the approved facility where the Covered Organ Transplant is performed; and (b) temporary lodging at a prearranged location during the Member's Confinement in an approved facility. These direct, non-medical costs are only available if the Member's immediate Family Member(s) live more than 100 miles from the approved facility.

DISEASE MANAGEMENT PROGRAMS

HUMANA BEGINNINGS

The "Humana Beginnings Program" is a service provided to Employees and their eligible Dependents of this Plan by the Plan Manager. This program is designed as a special service that helps mothers receive appropriate prenatal care.

- First, call the Precertification phone number shown on the back of Your ID card as soon as Your pregnancy has been confirmed by a Physician. When You call, one of the nurses will ask You questions such as: Your estimated date of delivery, if You had any problems with previous pregnancies, and Your ongoing medical conditions, just to name a few. These questions are held in confidence between You and the nurse You are speaking to. Answers to these questions, along with Your approval, will help the nurse and Your doctor decide whether You need special care during Your pregnancy.

- If You and/or Your baby need special care before or after delivery, a nurse is available to assist in managing Your care. The nurse will obtain the necessary consents from You to manage Your care. The nurse case manager will then monitor the treatment plan and facilitate with Your health care professional to ensure You are receiving the best care while getting the most out of Your health insurance benefits.

- If Your health care professional admits You to a Hospital during Your pregnancy, please follow the Precertification requirements defined in Your benefit booklet for emergency and planned Admissions.

- When You deliver Your baby, You may not feel up to calling the Plan Manager (or as indicated on Your ID card). Remind Your partner, relative or health care professional to call for You.

If You have any questions, call the Plan Manager (or as indicated on Your ID card) and one of our nurses will help You.

EXCLUSIONS AND LIMITATIONS

Unless specifically stated otherwise, no services will be provided or paid for or on account of:

1. Care for conditions that state or local law requires to be treated in a public facility;

2. Any charge which would not have been made if the Member had no coverage or any change the Member would not be legally required to pay;

3. Education, training or medical services provided by the Member's parent, spouse, brother, sister or Child;

4. Experimental drugs or substances not approved by the Food and Drug Administration, drugs or substances used for other than Food and Drug Administration approved indications or drugs labeled "Caution-limited by Federal law to investigational use";

5. Prescription drugs, including insulin and syringes, Diabetic Supplies, vitamins, birth control pills and non-prescription drugs or medicines;

6. Smoking cessation products;

7. Treatment, services, supplies or Surgery that is not Medically Necessary;

8. The purchase, fitting or repair of hearing aids or advice on their care;

9. Weekend non-emergency Hospital Admissions;

10. Infertility Services and artificial means of achieving pregnancy, including in-vitro fertilization, unless specifically provided under this Plan;

11. Sex change services;

12. Reversal of elective sterilization;

13. Any drug, biological product, device, medical treatment or procedure which is Experimental or Investigational, unless specifically provided under this Plan; any drug, biological product, device, medical treatment or procedure which is not covered as Experimental or Investigational (or similar) by the HCFA Medicare Coverage issues Manual; any drug, biological product, or device which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which lacks such approval at the time of its use or proposed use; or any drug or biological product categorized as a Treatment investigational New Drug (ND) by the U.S. Food and Drug Administration or as a Group C Treatment Protocol drug by the U.S. National Cancer institute at the time of its use or proposed use. Specifically excluded are: ambulatory blood pressure monitor, refractive keratoplasty or radial keratotomy, positron emission tomography (PET) scans, transurethral balloon dilation of prostate, immunotherapy for recurrent abortion, chemonucleolysis, biliary lithotripsy, home uterine activity monitor, immunotherapy for food allergy and percutaneous lumbar discectomy;

14. Cosmetic Surgery: No services will be provided for plastic, cosmetic or Reconstructive Surgery, unless a functional impairment is present. An objective functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. The presence of a psychological condition will not entitle a Member to coverage for plastic, cosmetic or Reconstructive Surgery unless all conditions are met.

    Coverage will be extended for Breast Reconstruction when the Member has had a Medically Necessary mastectomy, as determined by the Plan Manager;

Exclusions and Limitations Continued

15. Services and supplies for dental care including braces and dental appliances, treatment of the teeth or periodontium or Oral Surgery, unless the services are required for: (a) excision of partially or completely unerupted impacted wisdom teeth; (b) excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination; or (c) surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of mouth. Precertification is required. Services for the treatment of a dental Injury to a Sound Natural Tooth, including but not limited to extraction and initial replacement are covered if: (1) the care and treatment is provided within 24 months from the date of Injury; and (2) the Injury was not the result of biting or chewing. Precertification is required. The Plan will not cover dental implants, routine dental extractions or any treatment related to the preparation or fitting of dentures;

16. Dental osteotomies/orthagnothic Surgery;

17. Care and treatment of the feet, unless such services are Medically Necessary as determined by the Member's Primary Care Physician;

18. Orthotic devices, unless such orthotic devices are custom fitted to the Member. We do not provide coverage for the repair of orthotic devices;

19. For any service, supply or treatment conneeted with custodial care. We do not provide these services no matter who provides, prescribes, recommends or performs them. Custodial care means services designed to help a Member meet the needs of daily living, whether or not he or she is disabled. These services include help in:

    a. walking or getting in or out of bed;
    b. personal care such as bathing, dressing, eating, or preparing special diets; or
    c. taking medication which the Member would normally be able to take without help;

20. Enrollment in a health, athletic or similar club; or a weight loss or similar program;

21. Services for the treatment of obesity, including Surgery;

22. Purchase or rental of supplies of common household use including, but not limited to, exercise cycles; air purifiers; central or unit air conditioners; water purifiers; allergenic pillows or mattresses; or waterbeds;

23. Disposable medical supplies and materials, such as bandages and syringes;

24. Purchase or rental of: motorized transportation equipment, escalators or elevators, saunas or swimming pools or professional medical equipment including, but not limited to, blood pressure kits, supplies or attachments for any of these items;

25. Convenience or personal care services such as use of a telephone or television;

26. Elective abortion, unless the Primary Care Physician and the Group Plan agree and certify in writing that the pregnancy would endanger the life and health of the mother, or in the case of rape or incest;

27. Vision therapy/training;

28. Services to correct eye refractive disorders, eyeglass frames and lenses or contact lenses and the fitting or repair of eyeglass frames and lenses or contact lenses;

Exclusions and Limitations Continued

29. Routine physical examinations when required for occupation, employment, school, travel, premarital tests or examinations or for an insurance company;

30. Spinal manipulations and subluxations, unless Medically Necessary;

31. Any service, supply, care or treatment that is not described in the Plan. Services performed as a result of a complication, regardless of whether the original service was a Covered Expense under this Group Plan, are covered;

32. Any service performed in association with a service that is not covered under this Group Plan;

33. Service provided prior to the effective date or after the termination date of Your coverage under the Group Plan;

34. Any and all services related to organ or artificial organ transplants or organ donations, except as specifically provided in the Organ Transplant Services subsection of this Group Plan;

35. Any service or supply received in, or in connection with, a Veterans Hospital or other government facility or program due to, or in connection with, a condition or disability resulting from service in an armed force or military and for which the Member has no legal liability for payment;

36. Services and supplies which are: (a) rendered in connection with Mental Illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; (b) extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation; (c) for occupational counseling; (d) for sex therapy; or (e) for Mental Illnesses which, according to generally accepted professional standards, are not usually amenable to favorable modification;

37. Treatment or diagnosis of sexual dysfunction/impotence;

38. Professional pathology or radiology charges, including but not limited to, blood counts and other clinical chemistry tests, when:

    a. The services do not require a professional interpretation, or
    b. The Physician did not provide a specific professional interpretation of the test results of the Covered Person;

39. Any bodily Injury or Sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:

    a. Benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, or
    b. Coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually purchased;

40. Bereavement;

41. Sickness or bodily Injury for which medical payments/personal injury protection (PIP) coverage exists under any automobile, homeowner, marine, aviation, premise, or any other similar coverage, whether such coverage is in effect on a primary, secondary, or excess basis. This exclusion applies up to the available limit under the other coverage regardless of whether a claim is filed with the medical payments/PIP carrier. Whether medical payment or expense coverage is payable under another coverage is to be determined as if the coverages under this Plan did not exist;

Exclusions and Limitations Continued

42. Any Covered Expenses to the extent of any amount received from others for the bodily Injuries or losses which necessitate such benefits. "Amounts received from others" specifically includes, without limitation, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments;

43. Any expense due to commission or attempt to commit a civil or criminal battery or felony;

44. Any loss caused by or contributed to:

    a. War or any act of war, whether declared or not, or
    b. Any act of armed conflict, or any conflict involving armed forces of any authority.

PLAN DESCRIPTION INFORMATION

1. Proper Name of Plan: Cinergy Services, Inc. Welfare Benefits Program

2. Plan Sponsor and Employer: Cinergy Services, Inc.
139 E. Fourth St.
Cincinnati, OH 45202
Telephone: 513-287-3333

This Plan is maintained under a collective bargaining agreement. A copy of the agreement may be obtained on written request and is available for examination.

3. Plan Administrator and Named Fiduciary:

Cinergy Services, Inc.
139 E. Fourth St.
Cincinnati, OH 45202
Telephone: 513-287-3333

4. Employer Identification Number: 31-1385023
The Plan number assigned for government reporting purposes is 506.

5. The Plan provides medical benefits for participating Employees, Retirees and their enrolled Dependents.

6. Plan benefits described in this booklet are effective January 1, 2004; revised January 1, 2006.

7. The Plan year and fiscal year are January 1 through December 31 of each year.

8. Service of legal process may be served upon the Plan Administrator as shown above or the following agent for service of legal process:

Attn: Marc Manly, Executive Vice President & Chief Legal Officer
Cinergy Services, Inc.
139 E. Fourth St.
Cincinnati, OH 45202

9. The Plan Manager is responsible for performing certain delegated administrative duties, including the processing of claims. The Plan Manager is:

Humana Insurance Company
500 West Main Street
Louisville, KY 40202
Telephone: Refer to Your ID card

10. This is a self-insured and self-administered health benefit plan. Cinergy Services, Inc. pays for the cost of benefits. Employees and Retirees may be required to reimburse Cinergy Services, Inc. for a portion of the cost of the Plan (such portion may vary by Employee and Retiree classification). Benefits under the Plan are provided from the general assets of the Employer and are used to fund payment of covered claims under the Plan plus administrative expenses. Please see Your Employer for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this Plan.

Plan Description Information Continued

11. Each Employee and Retiree of the Employer who participates in the Plan receives a Summary Plan Description, which is this booklet. This booklet will be provided to Employees and Retirees by the Employer. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.

12. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Plan Sponsor. Significant changes to the Plan, including termination, will be communicated to participants as required by applicable law.

13. Upon termination of the Plan, the rights of the participants to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the participating Employees and their Dependents covered by the Plan, except that any taxes and administration expenses may be made from the Plan assets.

14. The Plan does not constitute a contract between the Employer and any Covered Person and will not be considered as an inducement or condition of the employment of any Employee. Nothing in the Plan will give any Employee the right to be retained in the service of the Employer, or prohibit the Employer from discharging any Employee at any time.

15. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

16. Humana Insurance Company has agreed to provide medical management, claims processing, and service center call handling services to Members in the Plan. The Health Services covered under this Plan will be provided by and through the extensive Humana panel of Participating Providers. Humana does not underwrite any of the Plan's benefits, and Members in this Plan are not insured by Humana. The Plan Administrator shall have the sole and absolute discretionary authority to construe and interpret the provisions of the Plan, including but not limited to, making all determinations of covered medical expenses and other benefits of the Plan. All decisions and actions of the Plan Administrator in this regard shall be conclusive upon all interested parties.

STATEMENT OF ERISA RIGHTS

As a participant in the Cinergy Services, Inc. Welfare Benefits Program, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request from the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

1. Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents on the rules governing Your COBRA continuation coverage rights.

2. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under Your group health Plan, if You have Creditable Coverage from another Plan. You should be provided a certificate of Creditable Coverage, free of charge, from Your group Plan or insurance issuer when:

   a. You lose coverage under the Plan;
   b. You become entitled to elect COBRA continuation coverage; or
   c. Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage.

   Without evidence of Creditable Coverage, You may be subject to pre-existing condition exclusion for 12 months (18 months for Late Enrollee) after Your Enrollment Date.

PRUDENT ACTIONS OF PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of Employee benefit plans. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your Employer, Your union or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Statement of ERISA Rights Continued

ENFORCE YOUR RIGHTS

If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 Days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $ 110 a Day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relation's order or a Medical Child Support Order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees if, for example, it finds Your claim is frivolous.

ASSISTANCE WITH QUESTIONS

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Cinergy Corp.
Traditional Dental Plan

CIGNA DENTAL PREFERRED
PROVIDER INSURANCE

EFFECTIVE DATE: January 1, 2006

ASO04
3308712 – DPPO1

This document printed in February, 2006 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY CINERGY CORP. WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CONNECTICUT GENERAL DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CONNECTICUT GENERAL. BECAUSE THE PLAN IS NOT INSURED BY CONNECTICUT GENERAL, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CG," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

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Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

CIGNA HealthCare

Effect of Section 125 Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 Regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise you will receive your taxable earnings as cash (salary).

Provisions in this certificate which allow for enrollment or coverage changes not consistent with Section 125 Regulations are superseded by this section.

Coverage Elections

Per Section 125 Regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if you enroll for or change coverage within 31 days of the following:

Special Enrollment

Special Enrollment per federal requirements as described in the Section entitled "Eligibility – Effective Date/Enrollment Exception" if included in this document.

GM 6000 SCT125V1M

Change in Status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of dependents due to birth, adoption, placement for adoption or death of a dependent;
- change in employment status of Participant, spouse or dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under Family and Medical Leave Act (FMLA) or change in worksite;
- changes in employment status of Participant, spouse or dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Participant, spouse or dependent impacting their network access to a dental plan; and
- changes which cause a dependent to become eligible or ineligible for coverage.

Any changes in coverage must pertain directly to the change in status.

Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may in accordance with plan terms automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage.

GM6000 SCT125V2 M

How To File Your Claim

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office.

Dental Expenses

The first Dental Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

You must follow the Predetermination of Benefits procedure when it is necessary for dental forms.

CLAIM REMINDERS:

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

  YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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CIGNA HealthCare

Accident and Health Provisions

Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CG receives the notice of claim, it will give to the claimant, or to the Employer for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not receive these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss requirements if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

The Employer, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

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Eligibility - Effective Date

Eligibility For Participant Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Participants; and
- you are an eligible, full-time and/or part-time Participant; and
- you normally work at least 20 hours a week.

If you were previously insured and your insurance ceased, you must satisfy the New Participant Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Participants, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Participants within one year after your insurance ceased.

Initial Participant Group: You are in the Initial Participant Group if you are employed in a class of participants on the date that class of participants becomes a Class of Eligible Participant as determined by your Employer.

New Participant Group: You are in the New Participant Group if you are not in the Initial Participant Group.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

Initial Participant Group: None.

New Participant Group: None.

Classes of Eligible Participants

Each Participant as reported to the insurance company by your Employer.

GM6000 EL 2V-31
EL15 M

Participant Insurance

This plan is offered to you as an Participant. To be insured, you will have to pay part of the cost.

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction form, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

GM6000 EF 1
EL17V82 M

Enrollment Exception

A person will not be denied enrollment when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to such existing coverage; he lost coverage due to the employer's failure to pay premiums; he is no longer eligible for prior coverage; or if such prior coverage was continuation coverage and the continuation period has been exhausted: and he enrolls for this coverage within 30 days after losing or exhausting prior coverage.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 31 days of such event. Coverage will be effective, on the date of marriage, birth, adoption, or placement for adoption.

CIGNA HealthCare

Dependent Insurance

For your Dependents to be insured, you will have to pay part of the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

You will not be eligible to enroll your Dependents if you do not enroll them within 31 days of the date you become eligible, unless you qualify under the section of this certificate entitled "Enrollment Exception."

GM6000 EF 2V-1
ELJ10 M

CIGNA HealthCare

CIGNA Dental Preferred Provider Insurance

The Schedule

For You and Your Dependents

The Schedule
The Dental Benefits shown in this schedule apply to services rendered by Participating and Non-Participating Providers.

Emergency Services

The Benefit Percentage for Emergency Services incurred for charges made by a Non-Participating Provider is the same Benefit Percentage as for Participating Provider Charges. Dental Emergency services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

Deductibles
Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that year.

Simultaneous Accumulation of Amounts

Expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule.

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER & NON-PARTICIPATING PROVIDER
Classes I, II, III Combined Calendar Year Maximum	$1,500
Class IV Lifetime Maximum	$1,500
Calendar Year Deductible Individual Family Maximum	 $ 50 per person $ 150 per family

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BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER & NON-PARTICIPATING PROVIDER
Class I Preventive Care	Plan pays 100% There is no Deductible
Class II Basic Restorative	80% after plan deductible
Class III Major Restorative	50% after plan deductible
Class IV Orthodontia	Plan pays 50% There is no deductible
Class IV Orthodontia applies only to a Dependent Child less than 19 years of age.	

CIGNA HealthCare

Dental Benefits

Covered Dental Expense

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule has been met;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

GM6000 DEN160

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment. If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, CG recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by CG's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

CG will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, CG will determine covered dental expenses when it receives a claim.

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

GM6000 DEN161 M

Covered Services

The following section lists covered dental services. CG may agree to cover expenses for a service not listed. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to CG.

GM6000 DEN166V2

Dental PPO – Participating And Non-Participating Providers

Payment for a service delivered by a Participating Provider is the Contracted Fee, times the benefit percentage that applies to the class of service, as specified in the Schedule.

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating Provider is the Maximum Reimbursable Charge times the benefit percentage that applies to the class of service, as specified in the Schedule.

The covered person is responsible for the balance of the provider's actual charge.

GM6000 DES426

Class I Services – Diagnostic And Preventive

Clinical oral examination – Only 2 per person per calendar year.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

X-rays – Complete series – Only one per person, including panoramic film, in any 3 calendar years.

Bitewing x-rays – Only 2 charges per person per calendar year.

Panoramic (Panorex) x-ray – Only one per person in any 3 calendar years.

Prophylaxis (Cleaning) – Only 2 per person per calendar year.

Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Only two per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth for a person less than 19 years old – Only one treatment per tooth in any 3 calendar years.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment for a person less than 19 years old.

GM6000 DES297V5

CIGNA HealthCare

Class II Services – Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance And Oral Surgery

Amalgam Filling – One Surface
Composite/Resin Filling, One Surface
Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.
Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.
Periodontal Scaling and Root Planing – Entire Mouth
Adjustments – Complete Denture
Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.
Recement Bridge
Routine Extractions
Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth
Removal of Impacted Tooth, Soft Tissue
Removal of Impacted Tooth, Partially Bony
Removal of Impacted Tooth, Completely Bony
Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by CG, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
I. V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by CG, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

GM6000 DES298V5

Class III Services - Major Restorations, Dentures And Bridgework

High Noble Metal (gold) or Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

Crowns
Porcelain Fused to High Noble Metal
Full Cast, High Noble Metal
Three-Fourths Cast, Metallic
Fixed or Removable Appliances
Complete (Full) Dentures, Upper or Lower
Partial Dentures
Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)
Bridge Pontics - Cast High Noble Metal
Bridge Pontics - Porcelain Fused to High Noble Metal
Bridge Pontics - Resin with High Noble Metal
Retainer Crowns - Resin with High Noble Metal
Retainer Crowns - Porcelain Fused to High Noble Metal
Retainer Crowns - Full Cast High Noble Metal

GM6000 DES302V5

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

Continued active treatment after the first month.

Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

The total amount payable for all expenses incurred for Orthodontics for a Dependent child less than 19 years of age during his lifetime will not be more than the Orthodontia Maximum shown in the Schedule.

Payments for comprehensive full-banded Orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first payment is due when the appliance is installed. Later payments are due at the end of each 3-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while such child is insured. If insurance coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

GM6000 DES462

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Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;

GM6000 DEN183

- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- orthodontic services or supplies for any person other than a Dependent child less than 19 years of age;
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant;
- services for which benefits are not payable according to the "General Limitations" section.

GM6000 DEN186

General Limitations

Dental Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

GM6000 GEN312V4

Coordination Of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for dental care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

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Closed Panel Plan
A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan
The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan
A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

GM6000 COB11 V7

Allowable Expense
A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.
Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period
A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

GM6000 COB12

Reasonable Cash Value
An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules
A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an participant shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 COB13

- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

CIGNA HealthCare

- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. CG will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

GM6000 COB14 V7

As each claim is submitted, CG will determine the following:

- CG's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, CG will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If CG pays charges for benefits that should have been paid by the Primary Plan, or if CG pays charges in excess of those for which we are obligated to provide under the Policy, CG will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CG will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

CG, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

GM6000 COB15

Right of Reimbursement

The Policy does not cover:

1. Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Dependent(s).
2. Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government insurance, other than Medicaid, or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur health care Expenses as described in (1) and (2) above, Connecticut General shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the Policy. You or your Dependent(s) or their representative shall execute such documents as may be required to secure Connecticut General's rights. Connecticut General shall be reimbursed the lesser of:

the amount actually paid by CG [or the HealthPlan] under the Policy; or

an amount actually received from the third party;

at the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

GM6000 CCP1 CCL1V4

CIGNA HealthCare

Payment of Benefits

To Whom Payable

All Dental Benefits are payable to you. However, at the option of CG and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

GM6000 POB12
PMT135V16

Termination of Insurance

Participants

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Participants or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer cancels the insurance.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer cancels the insurance.

GM6000 TRM15V44 M

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day of birth month for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the last day of the birth month that Dependent no longer qualifies as a Dependent.

GM6000 TRM309 M

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

GM6000 BE6
BEX131V7

CIGNA HealthCare

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

FDRL1

Notice Regarding Provider Directories and Provider Networks

If your Plan utilizes a network of Providers, you may without charge, receive a separate listing of Participating Providers.

You may also have access to a list of Providers who participate in the network by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider network consists of a group of local dental practitioners, of varied specialties as well as general practice, who are employed by or contracted with CIGNA HealthCare or CIGNA Dental Health.

GM6000 NOT86

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependent as follows:

You may continue benefits, by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to apply or return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

NOT141

Reinstatement of Benefits (Applicable To All Coverages)

If your coverage ends during the leave because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if, (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-existing Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply. Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

NOT142

Notice of Federal Requirements

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the social security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost-effective. This includes premiums for continuation coverage required by federal law.

GM6000 NOT99

Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA'93)

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, as amended, where applicable.

CIGNA HealthCare

A. Eligibility for Coverage Under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the Qualified Medical Child Support Order being issued.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

OBRA1

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with State laws regarding child health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a State official whose name and address have been substituted for the name and address of the child.

B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

OBRA4

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline

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COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.
The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections below titled "Secondary Qualifying Events" and "Medicare Extension for Your Dependents" are not applicable to these individuals.

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Secondary Qualifying Events
If, as a result of your termination of employment or reduction in workhours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension
If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents
When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

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Termination of COBRA Continuation
COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with CIGNA;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of (1), (2) or (3) above; or
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

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Employer's Notification Requirements
Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's)

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coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.

- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  (a) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  (b) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  (c) in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.
Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

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How Much Does COBRA Continuation Coverage Cost

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member. For example:

- If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium.
- If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium.
- If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is

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suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

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You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation;
- Your child ceases to qualify as a Dependent under the Plan; or
- The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled "Disability Extension" for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

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Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under "Termination of COBRA Continuation" above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

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Requirements of Family and Medical Leave Act of 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified

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by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

GM6000 TRM191V1

ERISA Required Information

The name of the Plan is:

Cinergy Corp. Health & Welfare Benefits Plan

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

Cinergy Corp.
139 E. 4th St. Rm 442
Cincinnati, OH 45202
513-287-3333

Employer Identification Number (EIN)	Plan Number
311385023	506

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for the service of legal process is:

Employer named above (May be Plan trustee, if any; or Plan Administrator.)

The office designated to consider the appeal of denied claims is:

The CG Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The Plan's fiscal year ends on 12/31

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

GM6000 ERISA31

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The Plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to CG the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to CG the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

GM6000 ERISA29

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of Employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of Employees may be changed or terminated, or by which part or all of the Plan may be terminated, is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. No consent of any participant is required to terminate, modify, amend or change the Plan.

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Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to your or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the last day of the calendar month in which you leave Active Service;
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute; or
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

GM6000 ERISA15

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:.

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

ERISA39

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people responsible for the operation of the Employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court.

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In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

GM6000 ERISA20

Claim Determination Procedures Under ERISA

The following complies with federal law effective July 1, 2002. Provisions of the laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be medically necessary to be covered under the plan. The procedures for determining medical necessity vary, according to the type of service or benefit requested, and the type of health plan.

You or your authorized representative (typically, your health care provider) must request medical necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not medically necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents, and in the determination notices.

Postservice Medical Necessity Determinations

When you or your representative requests payment for services that include a medical necessity determination, CG will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control CG will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed. The determination period will be suspended on the date CG sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

GM6000 ERISA24

Procedures Regarding Claim Payment Determinations

Postservice Claim Determinations

When you or your representative requests payment for services which have been rendered, CG will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control, CG will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you and your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: 1. the specific reason or reasons for the adverse determination; 2. reference to the specific plan provisions on which the determination is based; 3. a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; 4. a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; 5. upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; 6. in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

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Assistance With Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You

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may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CG will provide administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration.

Benefits provided under this plan are self-insured by the Employer.

This document is issued by:

Connecticut General Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

ERISA41

When You Have A Complaint or An Appeal

The following complies with federal law and is effective July 1, 2002. Provisions of the laws of your state may supersede.

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the toll-free number on your Benefit Identification card explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You can also express that concern in writing. We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

CG has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CG within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CG to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits, or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

GM6000 APL262

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review of non-urgent care claims. To initiate a level two appeal, follow the same process required for a level one appeal except send this appeal to the entity responsible for administering the Level Two Appeal Process. The Appeal Committee review of your claim will be completed within 30 calendar days. If more time or information is needed to make the determination, you will be notified in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Appeal Committee to complete the review. You will be notified in writing of the Appeal Committee's decision within five business days after the Appeal Committee meeting, and within the Appeal Committee review time frames above if the Appeal Committee does not approve the requested coverage. The Appeal Committee referred to in the Level Two Appeal means the organization performing the second level appeal.

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Independent Review Procedure

If you are not fully satisfied with the decision of CG's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CG or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical

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appropriateness determination by CG. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.
To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CG level two appeal review denial. CG will then forward the file to the Independent Review Organization.
The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by CG's Dentist reviewer, the review shall be completed within three days.
The Independent Review Program is a voluntary program arranged by CG.

GM6000 APL265

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.
You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the Level One and Level Two appeal processes. If your appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

GM6000 APL266

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

DFS1

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

DFS17

Contracted Fee - CIGNA Dental Preferred Provider

The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on an Employee or Dependent, according to the Employee's dental benefit plan.

DFS1217

CIGNA HealthCare

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Dental Services described in the policy.

DFS24

Dependent

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is
  - less than 19 years old;
  - 19 years but less than 25 years old, enrolled in school as a full-time student and primarily supported by you;
  - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child. It also includes a stepchild who lives with you.

Benefits for a Dependent child or student will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

DFS57

Employee

See the definition for Participant.

DFS211

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf CG is providing claim administration services.

DFS1595

Maximum Reimbursable Charge

The Maximum Reimbursable Charge is the lesser of:

1. the provider's normal charge for a similar service or supply; or
2. the policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.

To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the Injury or Sickness may be considered.

CG uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually.

The percentile used to determine the Maximum Reimbursable Charge is listed in the Schedule.

Additional information about the Maximum Reimbursable Charge is available upon request.

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Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

DFS192

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

DFS149

Participant

The term Participant means a full-time or part-time employee of the Employer, or a person who retired from the Employer in an eligible group. The term does not include employees who are part-time or temporary or who normally work less than 20 hours a week for the Employer.

Participating Provider - CIGNA Dental Preferred Provider

The term Participating Provider means: a dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a contract with CG to provide dental services at predetermined fees.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by your Employer.

DFS1218

SCI DOC ID 478864
RIGHT HAND PAGE

Summary Plan Description

United HealthCare Out of Area Plan

for

Cinergy Corp.

Group Number: 239203

Effective Date: January 1, 2004

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Introduction

We are pleased to provide you with this Summary Plan Description (SPD). This SPD describes your Benefits, as well as your rights and responsibilities, under the Plan.

How to Use this Document

We encourage you to read your SPD and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitation of this SPD by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions). You should also carefully read (Section 9: General Legal Provisions) to better understand how this SPD and your Benefits work. You should call the Claims Administrator if you have questions about the limits of the coverage available to you.

Many of the sections of the SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. We encourage you to keep your SPD and any attachments for your future reference.

Please be aware that your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

To continue reading, go to right column on this page.

Information about Defined Terms

Because this SPD is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 10: Glossary of Defined Terms). You can refer to Section 10 as you read this document to have a clearer understanding of your SPD.

When we use the words "we," "us," and "our" in this document, we are referring to the Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in (Section 10: Glossary of Defined Terms).

Your Contribution to the Benefit Costs

The Plan may require the Participant to contribute to the cost of coverage. Contact your Benefits representative for information about any part of this cost you may be responsible for paying.

Customer Service and Claims Submittal

Please make note of the following information that contains Claims Administrator department names and telephone numbers.

Customer Service Representative (questions regarding Coverage or procedures): As shown on your ID card.

Care Coordination℠/Notification: As shown on your ID card.

Mental Health/Substance Abuse Services Designee: As shown on your ID card.

To continue reading, go to left column on next page.

Claims Submittal Address:

United HealthCare Insurance Company

PO Box 740800

Atlanta, GA 30374-0800

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Insurance Company

PO Box 740816

Atlanta, GA 30374-0816

Internet:

We also encourage you to visit the Claims Administrator's website, www.myuhc.com, to take advantage of several self-service features including: viewing your claims' status, ordering ID cards and finding Network Physicians in your area.

To continue reading, go to right column on this page.

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).
- Covered Health Services that require you to notify Care Coordination℠ or the Mental Health/Substance Abuse Designee before you receive them.

Accessing Benefits

You can choose to receive Benefits from any Physician or provider.

Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your Copayment level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

To continue reading, go to right column on this page.

You should show your identification card (ID card) every time you request health care services so that the provider will know that you are enrolled under the Plan.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 8: When Coverage Ends) occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Copayment

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment, see (Section 10: Glossary of Defined Terms). Copayment amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Copayments are calculated as a percentage (rather than as a set dollar amount) the percentage is based on Eligible Expenses.

Eligible Expenses

Eligible Expenses are the amount that we will pay for Benefits as determined by us or by our designee once you have met your Annual Deductible. In almost all cases our designee is the Claims Administrator. For a complete definition of Eligible Expenses that describes how payment is determined, see (Section 10: Glossary of Defined Terms).

We have delegated to the Claims Administrator the discretion and authority to initially determine on our behalf whether a treatment or

To continue reading, go to left column on next page.

supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

For Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills, unless you agreed to reimburse the provider for such services. For non-Network Benefits, except for fees that are negotiated by a non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

Notification Requirements

Prior notification is required before you receive certain Covered Health Services. You are responsible for notifying Care Coordination℠ before you receive these Covered Health Services.

For Mental Health/Substance Abuse Services you are responsible for notifying the Mental Health/Substance Abuse Designee.

Services for which you must provide prior notification appear in this section under the *Must You Notify Care Coordination℠?* column in the table labeled *Benefit Information.* Some of the services requiring notification include:

- Accidental Dental Services.
- Durable Medical Equipment over $1,000.
- Home Health Care.
- Hospice Care.
- Hospital Confinements.

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- Maternity Care that exceeds 48 hours for normal delivery and 96 hours for Caesarian birth.
- Inpatient Mental Health and Substance Abuse Services.
- Reconstructive Procedures.
- Skilled Nursing/Inpatient Rehabilitation Facility Confinement.
- Transplant Services.
- Breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature.

To notify Care Coordination℠ or the Mental Health/Substance Abuse Designee, call the telephone number on your ID card for Claims Administration.

We urge you to confirm with Care Coordination℠ that the services you plan to receive are Covered Health Services, even if not indicated in the *Must You Notify Care Coordination℠?* column. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reduction and reconstruction (except for after cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.
- The Experimental or Investigational Services or Unproven Services exclusion.

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- Any other limitation or exclusion of the Plan.

Special Note Regarding Medicare

If you are enrolled for Medicare on a primary basis (Medicare pays before we pay Benefits under the Plan), the notification requirements described in this SPD do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in (Section 7: Coordination of Benefits). You are not required to notify Care Coordination[SM] before receiving Covered Health Services when Medicare is the primary payer.

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Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms).	$200 per Covered Person per calendar year, not to exceed $400 for all Covered Persons in a family.
Copayment	The charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses.	***Network and Non-Network*** See each Benefit in **Section 1: What's Covered - - Benefits** for further information.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	$1,200 per Covered Person per calendar year, not to exceed $2,400 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.
Maximum Plan Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Plan. For a complete definition of Maximum Plan Benefit, see (Section 10: Glossary of Defined Terms).	$2,000,000 per Covered Person.

Benefit Information

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services Acupuncture services for pain therapy when both of the following are true: • Another method of pain management has failed. • The service is performed by a provider in the provider's office. Where such Benefits are available, acupuncture is a Covered Health Service for the treatment of: • Nausea of chemotherapy, or • Post-operative nausea, or • Nausea of early Pregnancy. Benefits are limited to 20 visits per calendar year.	No	$15 per visit	No	No
2. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	No	*Ground Transportation:* 10% *Air Transportation:* 10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
3. Ambulance Services - Non-Emergency Transportation by professional ambulance, other than air ambulance, to and from a medical facility. Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment. Note: Except in life threatening circumstances, notification for Air Ambulance transport is required	No	*Ground Transportation:* 10% *Air Transportation:* 10%	Yes	Yes
4. Christian Science Practitioner Covered Health Services rendered when: • The frequency is reasonable and comparable to treatment by another health care provider. • The Christian Science Nurse or Practitioner is listed in the Christian Science Journal at the time the charge is made.	No	$15 per visit No Copayment applies when no Physician charge is assessed	Yes	Yes
5. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 48 hours of the accident.	Yes	*Office Visit:* $15 *Alternate Setting:* 10%	No Yes	No Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

- A virgin or unrestored tooth, or
- A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be both of the following:

- Started within three months of the accident.
- Completed within 12 months of the accident.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

Notify Care Coordination℠

Please remember that you should notify Care Coordination℠ as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.) When you provide notification, Care Coordination℠ can verify that the service is a Covered Health Service.

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
6. Diagnostic and Therapeutic Services Covered Health Services received on an outpatient basis including: • Lab and radiology/X-ray. • Mammography testing. • Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy). A standard test (such as a Mammogram, PSA or Pap Smear) associated with an annual preventative screening will be covered at 100%. If additional follow-up testing is required, the standard Copayment will apply. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	No	10%	Yes	Yes
7. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet	Yes, for items more than $1,000.	10%	Yes	Yes

your functional needs, Benefits are available only for the most cost-effective piece of equipment.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen concentrator units and the rental of equipment to administer oxygen.
- Delivery pumps for tube feedings.
- Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service, including necessary adjustments to shoes to accommodate braces.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions.
- Diabetic pumps.

We provide Benefits for a single unit of Durable Medical Equipment (example one insulin pump) and provide repair for that unit.

Care Coordination℠ will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor Care Coordination℠ identifies.

Notify Care Coordination℠

Please remember that you must notify Care Coordination℠ before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
single item). If you don't notify Care Coordination℠, Benefits for Durable Medical Equipment will be subject to a $300 penalty.				
8. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits). The $75 Emergency Health Services Copayment is waived if the Covered Person is admitted to a Hospital. Additionally, no Benefits are provided if the service is deemed to be non-Emergency in nature. **Notify Care Coordination℠** Please remember that if you are admitted to a Hospital as a result of an Emergency, you must notify Care Coordination℠ within two business days or the same day of admission, or as soon as reasonably possible. If you don't notify Care Coordination℠, Benefits for the Hospital Inpatient Stay will be subject to a $300 penalty. Benefits will not be reduced for the outpatient Emergency Health Services.	Yes, but only for an Inpatient Stay.	$75 per visit	No	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
9. Home Health Care Services received from a Home Health Agency that are both of the following: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required. Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician. • It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair. • It requires clinical training in order to be delivered safely and effectively. • It is not Custodial Care. Care Coordination℠ will decide if skilled home health care is required by reviewing both the skilled nature of the service and the	Yes	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Benefits are limited to 40 visits per calendar year. One visit equals four hours of skilled care services. **Notify Care Coordination℠** Please remember that for Non-Network Benefits you should notify Care Coordination℠ five business days before receiving services. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.				
10. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. **Notify Care Coordination℠** Please remember that you should notify Care Coordination℠ five business days before receiving services. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.	Yes	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
11. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). **Notify Care Coordination℠** Please remember that you must notify Care Coordination℠ as follows: • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. • For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.	Yes	10%	Yes	Yes
12. Infertility Services Covered Health Services for the diagnosis and treatment of the underlying medical condition causing infertility when provided by or under the direction of a Physician.	No	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
13. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	No	*Office Visit:* $15 per visit *Injection Only:* 10%	Yes	Yes
14. Maternity Services Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify Care Coordination℠ during the first trimester, but no later than one month prior to the anticipated childbirth. We will pay Benefits for an Inpatient Stay of at least: • 48 hours for the mother and newborn child following a vaginal delivery. • 96 hours for the mother and newborn child following a cesarean section delivery. If the mother agrees, the attending provider may discharge the	Yes if Inpatient Stay exceeds time frames.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services. No Copayment applies to Physician office visits for prenatal care after the first visit.		

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
mother and/or the newborn child earlier than these minimum time frames. **Notify Care Coordination℠** Please remember that you must notify Care Coordination℠ as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If you don't notify Care Coordination℠ that the Inpatient Stay will be extended, your Benefits for the extended stay will be subject to a $300 penalty.				
15. Mental Health and Substance Abuse Services - Outpatient Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy). • Crisis intervention.	No	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Psychological testing. Benefits for Mental Health Services and/or Substance Abuse Services are limited to 50 visits per calendar year.				
16. Mental Health and Substance Abuse Services - Inpatient and Intermediate Mental Health Services and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being. The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. Benefits for Mental Health Services and/or Substance Abuse Services are limited to 30 days per calendar year. **Authorization Required** Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance	Yes	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Abuse Designee phone number appears on your ID card. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty				
17. Nutritional Counseling Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include: • Diabetes mellitus. • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias. Benefits are limited to three individual sessions during a Covered Person's lifetime for each medical condition.	No	10%	Yes	Yes
18. Outpatient Surgery Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including surgery and related services.	No	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services* below. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.				
19. Physician's Office Services Covered Health Services received in a Physician's office including: • Treatment of a Sickness or Injury. • Preventive medical care. • Well-baby and well-child care. • Routine well woman examinations, including pap smears, pelvic examinations and mammograms. • Routine well man examinations, including PSA examinations. • Routine physical examinations, including vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment or the fitting or purchase of eyeglasses or contact lenses.) • Immunizations. Benefits for immunizations are covered at 100%.	No	$15 per visit No Copayment applies when no Physician charge is assessed.	No	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
20. Private Duty Nursing Covered Health Services for private duty nursing care given on an outpatient basis when provided by a licensed nurse (R.N., L.P.N., or L.V.N.). Benefits are limited to a maximum of $5,000 per Covered Person per calendar year.	No	10%	Yes	Yes
21. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	No	10%	Yes	Yes
22. Prosthetic Devices Prosthetic devices that replace a limb or body part including: • Artificial limbs. • Artificial eyes. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. If more than one prosthetic device can meet your functional needs,	No	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits are available only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the direction of a Physician. We provide Benefits for a single purchase, including repairs, of a type of prosthetic device.				
23. Reconstructive Procedures Reconstructive procedures - services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored. Cosmetic Procedures - services are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function like breathing. This Plan does not provide Benefits for Cosmetic Procedures.	Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to improve appearance and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in appearance is the primary purpose of the procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. You can contact Care Coordination℠ at the telephone number on your ID card for more information about Benefits for mastectomy related services.

Notify Care Coordination℠

Please remember that you should notify Care Coordination℠ five business days before receiving services. When you provide notification, Care Coordination℠ can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage.

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
24. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy. • Occupational therapy. • Speech therapy • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. ***Speech Therapy for Children under Age Three*** Services of a licensed speech therapist for treatment given to a child under age three whose speech is impaired due to one of the following conditions: • Infantile autism.	No Yes	*Office Visit:* $15 *Alternate Setting:* 10%	No Yes	No Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Development delay or cerebral palsy. • Hearing impairment. • Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate. Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Benefits are limited as follows: • 20 visits of physical therapy per calendar year. • 20 visits of occupational therapy per calendar year. • 20 visits of speech therapy per calendar year.				
25. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Benefits are limited to 120 days per calendar year.	Yes	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

Please note that, in general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting.

The Covered Person is expected to improve to a predictable level of recovery.

Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are required intermittently (such as physical therapy three times a week).

Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

(Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)

Notify Care Coordination℠

Please remember that you must notify Care Coordination℠ as

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
follows: • For elective admissions: five business days before admission. • For non-elective admission: within one business day or the same day of admission. • For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible. If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.				
26. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day. Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition when the therapy, service or supply ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Benefits for Spinal Treatment are limited to 20 visits per calendar year.	No	$15 per visit	No	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
27. Temporomandibular Joint Dysfunction (TMJ) Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident, trauma, congenial defect, developmental defect, or orpathology. Please note that Benefits are not available for charges of services that are Dental in nature. Benefits are limited to a maximum of $1,500 per Covered Person per lifetime for non-surgical services and supplies relating to TMJ.		Office Visit: $15 Alternate Setting: 10%	No Yes	No Yes
28. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Physician. For the highest level of Benefits, services must be received at a Designated United Resource Network Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational Service or an Unproven Service. Care Coordination℠ notification is required for all transplant services. The services described under **Transportation and Lodging** below	Yes	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

are Covered Health Services **ONLY** in connection with a transplant received at a Designated United Resource Network Facility.

- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated United Resource Network Facility. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of $25,000 is payable for all charges made in connection with the search.
- Heart transplants.
- Heart/lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney/pancreas transplants.
- Liver transplants.
- Liver/small bowel transplants.
- Pancreas transplants.
- Small bowel transplants.

Benefits for cornea transplants that are provided by a Physician at a Hospital are paid as if the transplant was received at a Designated United Resource Network Facility. We do not require that cornea transplants be performed at a Designated United Resource Network

Facility.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by Care Coordination to be a proven procedure for the involved diagnoses.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact Care Coordination℠ at the telephone number on your ID card for information about these guidelines.

Transportation and Lodging

Care Coordination℠ will assist the patient and family with travel and lodging arrangements only when services are received from a Designated United Resource Network Facility. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Eligible Expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated United

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Resource Network Facility. • If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate. There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures. **Notify Care Coordination℠** You must notify Care Coordination℠ as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify Care Coordination℠, Benefits will be subject to a $300 penalty.				
29. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.	No	10%	Yes	Yes

Section 2: What's Not Covered--Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered. We call these Exclusions. It's important for you to know what services and supplies are not covered under the Plan.

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

Plan Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

To continue reading, go to right column on this page.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in (Section 1: Covered Health Services) or through a Rider to the SPD.

A. Alternative Treatments

1. Acupressure.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Services and supplies provided by a naturopath.
7. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - — Air conditioners.
   - — Air purifiers and filters.
   - — Batteries and battery chargers.
   - — Dehumidifiers.
   - — Humidifiers.
6. Devices and computers to assist in communication and speech.

To continue reading, go to left column on next page.

7. Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).

C. Dental

1. Dental care except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident Only.*
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
   — Extraction, restoration and replacement of teeth.
   — Medical or surgical treatments of dental conditions.
   — Services to improve dental clinical outcomes.
3. Dental implants.
4. Dental braces.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
   — Transplant preparation.
   — Initiation of immunosuppressives.
   — The direct treatment of acute traumatic Injury, cancer or cleft palate.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications.
3. Non-injectable medications given in a Physician's office except as required in an Emergency.

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4. Over the counter drugs and treatments.

E. Experimental or Investigational Services or Unproven Services

Experimental or Investigational Services and Unproven Services are excluded. The fact that an Experimental or Investigational Service or an Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

1. Except when needed for severe systemic disease:
   — Routine foot care (including the cutting or removal of corns and calluses).
   — Nail trimming, cutting, or debriding.
2. Hygienic and preventive maintenance foot care. Examples include the following:
   — Cleaning and soaking the feet.
   — Applying skin creams in order to maintain skin tone.
   — Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.
3. Treatment of flat feet.
4. Treatment of subluxation of the foot.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.

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2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   — Elastic stockings.
   — Ace bandages.
   — Gauze and dressings.
   — Syringes.
   — Diabetic test strips, monitors, and supplies (except for pumps).
3. Orthotic appliances that straighten or re-shape a body part (including some types of braces).
4. Tubings, nasal cannulas, connectors and masks are not covered except when used with Durable Medical Equipment (as described in Section 1: What's Covered--Benefits).

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Services for Mental Health and Substance Abuse that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Treatment for insomnia and other sleep disorders, dementia, neurological disorders and other disorders with a known physical basis.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

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5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee.
7. Residential treatment services.
8. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
   — Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   — Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   — Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   — Not consistent with the Mental Health/Substance Abuse Designee's guidelines or best practices as modified from time to time.

   The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.
9. Pastoral counselors.
10. Treatment provided in connection with autism provided under the *Mental Health/Substance Abuse* portion of the Plan. However,

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any services, treatments, items or supplies provided for in (Section 1: Covered Health Services) may be covered.

11. Treatment provided in connection with tobacco dependency.
12. Routine use of psychological testing without specific authorization.

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Except as described in (Section 1: What's Covered -- Benefits) under *Nutritional Counseling,* nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms.) Examples include:
   - — Pharmacological regimens, nutritional procedures or treatments.
   - — Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - — Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

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4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental Injury in excess of one per lifetime, up to a maximum of $500.

K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - — Has not been actively involved in your medical care prior to ordering the service, or
   - — Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography testing.

L. Infertility/Reproduction

1. Surrogate parenting.
2. The reversal of voluntary sterilization.

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3. Fees or direct payment to a donor for sperm or ovum donations.
4. Fees relating to Assisted Reproductive Technology. (Such as Artificial Insemination, Invitro Fertilization, GIFT & ZIFT.)
5. Monthly fees for maintenance and/or storage of frozen embryos.
6. Health services and associated expenses for elective abortion.
7. Contraceptive supplies and services.
8. Fetal reduction surgery.
9. Health services associated with an elective abortion or the use of non-surgical or drug-induced Pregnancy termination.
10. Voluntary Family Planning.

M. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

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N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer.
5. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in (Section 1: What's Covered--Benefits), unless determined by Care Coordination to be a proven procedure for the involved diagnoses.

O. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered services rendered at United Resource Networks participating programs or Designated Facilities may be reimbursed at our discretion.

P. Vision and Hearing

1. Purchase cost of eye glasses, contact lenses, or hearing aids.
2. Fitting charge for hearing aids, eye glasses or contact lenses.
3. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

To continue reading, go to left column on next page.

.Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - — Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - — Related to judicial or administrative proceedings or orders.
   - — Conducted for purposes of medical research.
   - — Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature, including oral appliances.

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9. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment *except as* a treatment of temporomandibular joint or obstructive sleep apnea.
11. Non-surgical treatment of obesity, including morbid obesity.
12. Surgical treatment of obesity including severe morbid obesity (with a BMI greater than 35).
13. Growth hormone therapy.
14. Sex transformation operations.
15. Custodial Care.
16. Domiciliary care.
17. Private duty nursing received on an inpatient basis.
18. Respite care.
19. Rest cures.
20. Psychosurgery.
21. Treatment of benign gynecomastia (abnormal breast enlargement in males).
22. Medical and surgical treatment of excessive sweating (hyperhidrosis).
23. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
24. Appliances for snoring.
25. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
26. Any charges relating to a Physician visit that was performed in the Covered Person's home.

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27. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
28. Any charge for services, supplies or equipment advertised by the provider as free.
29. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
30. Any charges prohibited by federal anti-kickback or self-referral statutes.
31. Any additional charges submitted after payment has been made and your account balance is zero.
32. Any outpatient facility charge in excess of payable amounts under Medicare.
33. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
34. Outpatient rehabilitation services, Spinal Treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
35. Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies.
36. Speech therapy to treat stuttering, stammering, or other articulation disorders.
37. Liposuction
38. Chelation therapy, except to treat heavy metal poisoning.
39. Personal trainer.
40. Naturalist.

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Section 3: Obtaining Benefits

This section includes information about:

- Benefits for Covered Health Services.
- Your responsibility for notification.
- Emergency Health Services.

Benefits for Covered Health Services

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider.

Please note that Mental Health and Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee. Please see (Section 1: What's Covered--Benefits) under the heading for *Mental Health and Substance Abuse.*

If You Obtain Services from a Network Provider

The Claims Administrator or its affiliate arranges for health care providers to participate in a Network. These Network providers have agreed to discount their charges for Covered Health Services.

If you use a Network provider, your Copayment amount will generally be less than it would be if you use a non-Network provider. The Copayment level will remain the same, but because the total amount of Eligible Expenses may be less when you use a Network provider, the portion that you owe will be less.

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Network providers are independent practitioners. They are not our employees or employees of the Claims Administrator. It is your responsibility to select your provider.

The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Separately, you will automatically be given a directory of Network providers at no cost to you. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You are responsible for verifying a provider's Network status prior to receiving services, even when you are referred by another Network provider. You can verify the provider's status by calling the Claims Administrator.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some products. Refer to your provider directory or contact the Claims Administrator for assistance.

Designated United Resource Network Facilities and Other Providers

If you have a medical condition that Care Coordination[SM] believes needs special services, they may direct you to a Designated United Resource Network Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise

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is limited, Care Coordination℠ may direct you to a non-Network facility or provider.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated United Resource Network Facility or other provider chosen by Care Coordination℠.

Your Responsibility for Notification

You must notify Care Coordination℠ before getting certain Covered Health Services. The details are shown in the *Must You Notify Care Coordination℠?* column in (Section 1: What's Covered--Benefits). If you fail to notify Care Coordination℠, Benefits are reduced or denied.

Prior notification does not mean Benefits are payable in all cases. Coverage depends on the Covered Health Services that are actually given, your eligibility status, and any benefit limitations.

Care Coordination℠

When you notify Care Coordination℠ as described above, they will work to implement the Care Coordination℠ process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

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- If you are confined in a Hospital after you receive Emergency Health Services, Care Coordination℠ must be notified within two business days or on the same day of admission if reasonably possible.
- If you are admitted as an inpatient to a Hospital within 24 hours of receiving treatment for the same condition as an Emergency Health Service, you will not have to pay the Copayment for Emergency Health Services. The Copayment for an Inpatient Stay will apply instead.

  Note: Please note that the Copayment for Emergency Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the Hospital. In this case, the Emergency Copayment will apply instead of the Copayment for an Inpatient Stay.

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Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person must complete an online enrollment through YBR (Your Benefits Resources) website or by calling the iPeople Center within 31 days of eligibility or during Annual Enrollment. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

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If You Are Eligible for Medicare

You will be responsible for the costs that Medicare would have paid if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

If you are enrolled in a Medicare+Choice (Medicare Part C) plan, you will be responsible for any additional costs or reduced benefits that result if you fail to follow the requirements of the Medicare+Choice plan. Please see *Medicare Eligibility* in (Section 9: General Legal Provisions) for more information about how Medicare may affect your Benefits.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	Eligible Person usually refers to an Employee or Retiree who meets the eligibility rules of this Plan. When an Eligible Person actually enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person and Participant, see (Section 10: Glossary of Defined Terms). If both spouses are Eligible Persons of the Plan Sponsor, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both. Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll without our written permission.	Cinergy Corp. determines who is eligible to enroll under the Plan.
Dependent	Dependent generally refers to the Participant's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms). Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent.	Cinergy Corp. determines who qualifies as a Dependent.

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date of hire or qualified status change if you complete an online enrollment through YBR (Your Benefits Resource) or by calling the iPeople Center within 31 days of the date the Eligible Person becomes eligible to enroll.
Open Enrollment Period	Eligible Persons may enroll themselves and their Dependents.	Cinergy Corp. determines the Open Enrollment Period. Coverage begins on the 1st day of the following calendar year.
New Eligible Persons	New Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date of the qualified status change if you enroll through the YBR (Your Benefit Resource) website or by calling the iPeople Center within 31 days of the event.
Adding New Dependents	Participants may enroll Dependents who join their family because of any of the following events: • Birth. • Legal adoption. • Placement for adoption. • Marriage. • Legal guardianship. • Court or administrative order.	Coverage begins on the date of the qualified status change if you enroll through the YBR (Your Benefit Resource) website or by calling the iPeople Center within 31 days of the event.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because required contributions were not paid on a timely basis.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

A special enrollment period applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - — Loss of eligibility (including, without limitation, legal separation, divorce or death).
  - — The employer stopped paying the contributions.
  - — In the case of COBRA continuation coverage, the coverage ended.

Event Takes Place (for example, a birth or marriage). Coverage begins on the date of the event if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the event.

Missed Initial Enrollment Period or Open Enrollment Period. Coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

Section 5: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Network provider, you do not have to file a claim. We pay these providers directly.
- If you receive Covered Health Services from a non-Network provider, you are responsible for filing a claim.

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact the Claims Administrator. However, you are responsible for meeting the Annual Deductible and for paying Copayments to a Network provider at the time of service, or when you receive a bill from the provider.

Filing a Claim for Benefits

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us through the Claims Administrator. You must file the claim in a format that contains all of the information required, as described below.

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You must submit a request for payment of Benefits within one year after the date of service. If a non-Network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, in our or the Claims Administrator's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

If a Participant provides written authorization to allow direct payment to a provider, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid by the Participant. We will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

A. Participant's name and address.
B. The patient's name, age and relationship to the Participant.
C. The member number stated on your ID card.
D. An itemized bill from your provider that includes the following:

- Patient Diagnosis
- Date(s) of service
- Procedure Code(s) and descriptions of service(s) rendered
- Charge for each service rendered

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- Provider of service Name, Address and Tax Identification Number

E. The date the Injury or Sickness began.

F. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

Through the Claims Administrator, we will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

A. The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider.

B. You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

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A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received, and may request a one time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45 days period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment

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could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72-hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48 hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

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Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

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Section 6: Questions and Appeals

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

To resolve a question or appeal, just follow these steps:

What to Do First

If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in (How to File a Claim) you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claims Administrator.

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If you are appealing an Urgent Care Claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact Customer Service immediately.

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims

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Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon written request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows:

For appeals of pre-service claims (as defined in How to File a Claim), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by us of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims (as defined in How to File a Claim), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by us of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from us as the Plan Administrator. Your second level appeal request must be submitted to us in writing within 60 days from receipt of the first level appeal decision.

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The Plan Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

Please note that our decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

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Section 7: Coordination of Benefits

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides Benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating Benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one benefit plan.

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some

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expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the Benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

1. "Coverage Plan" is any of the following that provides Benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
   a. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical Benefits under group or individual automobile contracts; and Medicare or other governmental Benefits, as permitted by law.
   b. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; Benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental Plans, unless permitted by law.

   Each contract for coverage under a. or b. above is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

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2. The order of benefit determination rules determine whether this Coverage Plan is a "Primary Coverage Plan" or "Secondary Coverage Plan" when compared to another Coverage Plan covering the person.

   When this Coverage Plan is primary, its Benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's Benefits. When this Coverage Plan is secondary, its Benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Coverage Plan's Benefits.

3. "Allowable Expense" means a health care service or expense, including deductibles and Copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides Benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an Allowable Expense. Dental care, routine vision care, outpatient prescription drugs, and hearing aids are examples of expenses or services that are not Allowable Expenses under the Plan. The following are additional examples of expenses or services that are not Allowable Expenses:

   a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.

   b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

   c. If a person is covered by two or more Coverage Plans that provide Benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   d. If a person is covered by one Coverage Plan that calculates its Benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its Benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.

   e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a Coverage Plan that provides health Benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes Benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.

6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

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Order of Benefit Determination Rules

When two or more Coverage Plans pay Benefits, the rules for determining the order of payment are as follows:

A. The Primary Coverage Plan pays or provides its Benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that does not contain a coordination of Benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of Benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan Hospital and surgical Benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide Non-Network Benefits.

C. A Coverage Plan may consider the Benefits paid or provided by another Coverage Plan in determining its Benefits only when it is secondary to that other Coverage Plan.

D. The first of the following rules that describes which Coverage Plan pays its Benefits before another Coverage Plan is the rule to use.

1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a Dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a Dependent; and primary to the Coverage Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of Benefits between the two Coverage Plans is reversed so that

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the Coverage Plan covering the person as an Employee, Retiree or Dependent is secondary and the other Coverage Plan is primary.

2. Child Covered Under More Than One Coverage Plan. The order of Benefits when a child is covered by more than one Coverage Plan is:

a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:

1) The parents are married;

2) The parents are not separated (whether or not they ever have been married); or

3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of Benefits is:

1) The Coverage Plan of the custodial parent;

2) The Coverage Plan of the spouse of the custodial parent;

3) The Coverage Plan of the noncustodial parent; and then

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4) The Coverage Plan of the spouse of the noncustodial parent.

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a Dependent of a person covered as a Retiree or an Employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a Dependent of an actively working spouse will be determined under the rule labeled D(1).
4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an Employee or Retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored.
5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an Employee or Retiree longer is primary.
6. If a husband or wife is covered under this Coverage Plan as a Participant and as an Enrolled Dependent, the Dependent Benefits will be coordinated as if they were provided under another Coverage Plan, this means the Participant's benefit will pay first.
7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

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Effect on the Benefits of this Plan

A. When this Coverage Plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. The difference between the benefit payments that this Coverage Plan would have paid had it been the Primary Coverage Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by this Coverage Plan to pay any Allowable Expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Coverage Plan will:

   1. Determine its obligation to pay or provide Benefits under its contract;
   2. Determine whether a benefit reserve has been recorded for the Covered Person; and
   3. Determine whether there are any unpaid Allowable Expenses during that claim determination period.

   If there is a benefit reserve, the Secondary Coverage Plan will use the Covered Person's benefit reserve to pay up to 100 percent of total Allowable Expenses incurred during the claim determination period. At the end of the claim determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, Benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.
C. This Coverage Plan reduces its Benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

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Medicare Benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled for Medicare. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare Benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under this Coverage Plan and other Coverage Plans. The Claims Administrator

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may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming Benefits.

The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Coverage Plan must give us any facts we need to apply those rules and determine Benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Coverage Plan. We will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means reasonable cash value of the Benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the Benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

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Section 8: When Coverage Ends

This section provides you with information about all of the following:

- Events that cause coverage to end.
- The date your coverage ends.
- Continuation of coverage under federal law (COBRA).

General Information about When Coverage Ends

We may discontinue this Benefit Plan and/or all similar benefit Plans at any time, as permitted or required by law.

If your coverage should end, your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred before your coverage ended, even if the underlying medical condition occurred before your coverage ended.

With the exception of a surviving spouse of the Participant, an Enrolled Dependent's coverage ends on the date the Participant's coverage ends or sooner if the Participant chooses to end the Dependent's coverage or as otherwise set forth in this SPD.

In some cases, you may have the right and option to choose to continue coverage at your expense, even though you may no longer qualify as an Employee, Retiree or Dependent. For more information on this issue, see this section's discussion of Continuation of coverage under federal law (COBRA).

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Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

Ending Event	What Happens
The Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms "Eligible Person", "Participant", "Dependent" and "Enrolled Dependent."
The Claims Administrator Receives Notice to End Coverage	Your coverage ends on the last day of the calendar month in which the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
Participant Retires or Is Pensioned	The coverage that you have as an Employee may be available to you in retirement. The Cinergy iPeople Center can provide you with this information as well as explain how to elect coverage as a retiree.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Participant that coverage has ended on the date the Plan Administrator identifies in the notice:

Ending Event	What Happens
Fraud, Misrepresentation or False Information	Fraud or misrepresentation, or because the Participant knowingly gave us or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent. During the first two years the Plan is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.
Material Violation	There was a material violation of the terms of the Plan.
Improper Use of ID Card	You permitted an unauthorized person to use your ID card, or you used another person's card.
Failure to Pay	You failed to pay a required contribution.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.

Coverage for a Handicapped Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of mental retardation or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental retardation or physical handicap.
- Depends mainly on the Participant for support.

Coverage will continue as long as the Enrolled Dependent is incapacitated and Dependent unless coverage is otherwise terminated in accordance with the terms of the Plan.

We will ask you to furnish the Claims Administrator with proof of the child's incapacity and dependency within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before the Claims Administrator agrees to this extension of coverage for the child, the Claims Administrator may require that a Physician chosen by us examine the child. We will pay for that examination.

The Claims Administrator may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's incapacity and dependency within 31 days of the Claims Administrator's request as described above, coverage for that child will end.

To continue reading, go to right column on this page.

For purposes of the Plan, a person who meets the definition of a Handicapped Child, as just explained, shall be considered a Dependent for coverage purposes.

Continuation of Coverage

If your coverage ends under the Plan, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

If you selected continuation coverage under a prior Plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior Plan or in accordance with the terminating events listed below, whichever is earlier.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

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- A Participant.
- A Participant's Enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under Federal Law.
- A Participant's former spouse.

Qualifying Events for Continuation Coverage under COBRA

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

A. Termination of the Employee from employment with us, for any reason other than gross misconduct, or reduction of hours; or
B. Death of the Participant; or
C. Divorce or legal separation of the Participant; or
D. Loss of eligibility by an Enrolled Dependent who is a child; or
E. Entitlement of the Participant to Medicare Benefits; or
F. The Plan Sponsor filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Participant and his or her Enrolled Dependents. This is also a qualifying event for any retired Participant and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

To continue reading, go to right column on this page.

Notification Requirements and Election Period for Continuation Coverage under COBRA

The Participant or other Qualified Beneficiary must notify the Plan Administrator within 60 days of the Participant's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Participant or other Qualified Beneficiary fails to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Participant is continuing coverage under federal law, the Participant must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Plan Administrator.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial premium due to the Plan Administrator must be paid on or before the 45th day after electing continuation.

COBRA Terminating Events

COBRA continuation coverage under the Plan will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Participant's employment was terminated or hours were reduced (i.e., qualifying event A.).

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If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Participant, divorce or legal separation of the Participant, loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events B., C., or D.).

C. For the Enrolled Dependents of a Participant who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Participant's Medicare entitlement.

D. The date coverage terminates under the Plan for failure to make timely payment of the premium.

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E. The date, after electing continuation coverage, that coverage is first obtained under any other group health Plan.

F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.).

G. The date the entire Plan ends.

H. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage.*

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.) and the Participant dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Employee's or Retiree's death. Terminating events B through G described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Participant becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Plan Administrator for information regarding the continuation period.

To continue reading, go to left column on next page.

Section 9: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning your Plan.

Plan Document

This document is the Plan document and the Summary Plan Description.

Relationship with Providers

The relationships between us, the Claims Administrator, and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Nor are they agents or employees of the Claims Administrator. Neither we nor any of our employees are agents or employees of Network providers. Neither we nor the Claims Administrator are liable for any act or omission of any provider.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

To continue reading, go to right column on this page.

The Claims Administrator is not considered to be an employer or Plan Administrator for any purpose with respect to the administration or provision of Benefits under this Plan.

The Plan Administrator is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Incentives to Providers

The Claims Administrator pays Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

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Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness.
- Capitation - a group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

The methods used to pay specific Network providers may vary. From time to time, the payment method may change. If you have questions about whether your Network provider's contract includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact the Claims Administrator at the telephone number on your ID card. They can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes the Claims Administrator may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact the Claims Administrator if you have any questions.

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Interpretation of Benefits

We and the Claims Administrator have sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and Amendments.
- Make factual determinations related to the Plan and its Benefits.

We and the Claims Administrator may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

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Amendments to the Plan

We reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Plan. Plan Amendments and Riders are effective on the date we specify.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Any change or Amendment to or termination of the Plan, its Benefits or its terms and conditions, in whole or in part, shall be made solely in a written Amendment (in the case of a change or Amendment) or in a written resolution (in the case of a termination), whether prospective or retroactive, to the Plan, in accordance with the procedures established by us. Covered Persons will receive notice of any material modification to the Plan. No one has the authority to make any oral modification to the SPD.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. The terms of this Plan may not be amended by oral statements made by the Plan Sponsor, the Plan Administrative Committee, the Claims Administrator, or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times we or the Claims Administrator may need additional information from you. You agree to furnish us and/or the Claims Administrator with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it we may delay or deny payment of your Benefits.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us or the Claims Administrator with all information or copies of records relating to the services provided to you. We or the Claims Administrator have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Participant's enrollment form. We and the Claims Administrator agree that such information and records will be considered confidential.

We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers

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may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we or the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan Administrator.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

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If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in (Section 7: Coordination of Benefits), we will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare+Choice (Medicare Part C) Plan on a primary basis (Medicare pays before Benefits under the Plan), you **should** follow all rules of that Plan that require you to seek services from that Plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare+Choice Plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, the Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits the Plan provided to Covered Persons, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Summary Plan Description, the Plan shall

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also have an independent right to be reimbursed by Covered Persons for the reasonable value of any services and Benefits the Plan provides to Covered Persons, from any or all of the following listed below.

- Third parties, including any person alleged to have caused a Covered Person to suffer injuries or damages.
- Any person or entity who is or may be obligated to provide Benefits or payments to a Covered Person, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to a Covered Person on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties".

Covered Persons agree as follows:

- That a Covered Person will cooperate with the Plan in a timely manner in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by the Plan,
  - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,

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  - appearing at depositions and in court, and
  - obtaining the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and/or the institution of legal action against a Covered Person.
- That the Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a Covered Person to pursue his or her damage/personal injury claim.
- That regardless of whether a Covered Person have been fully compensated or made whole, the Plan may collect from Covered Persons the proceeds of any full or partial recovery that a Covered Person or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection shall include, but not be limited to any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by the Plan may also be considered to be benefits advanced.

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- That Covered Persons agree that if they receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, the Covered Person will serve as a constructive trustee over the funds and failure to hold such funds in trust will be deemed as a breach of the Covered Persons duties hereunder.

- That Covered Persons or an authorized agent, such as the Covered Person's attorney, must hold any funds received from any potentially responsible party that are due and owed to the Plan, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the institution of legal action against the Covered Person.

- That the Plan shall be entitled to recover reasonable attorney fees from Covered Persons incurred in collecting from the Covered Person any funds held by the Covered Person that he or she recovered from any Third Party.

- That the Plan may set off from any future benefits otherwise allowed by the Plan the value of benefits paid or advanced under this section to the extent not recovered by the Plan.

- That Covered Persons will neither accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval, nor will the Covered Person do anything to prejudice the Plan's rights under this section.

- That Covered Persons will assign to the Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits the Plan provided, plus reasonable costs of collection.

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- That the Plan's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom Covered Persons are seeking recovery, to be paid before any other of the Covered Person's claims are paid.

- That the Plan's rights will not be reduced due to the Covered Person's own negligence.

- That the Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the Covered Persons name, which does not obligate the Plan in any way to pay the Covered Person part of any recovery the Plan might obtain.

- That the Plan shall not be obligated in any way to pursue this right independently or on behalf of the Covered Person.

- That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.

- That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan beneficiary, this section applies to the personal representative of the deceased Plan beneficiary.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.

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- All or some of the payment we made exceeded the Benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future Benefits.

Limitation of Action

You cannot bring any legal action against us or the Claim Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in (Section 5: How to File a Claim) and all required reviews of your claim have been completed. If you want to bring a legal action against us or the Claims Administrator you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us or the Claims Administrator.

You cannot bring any legal action against us or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against us or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against us or the Claims Administrator.

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Section 10: Glossary of Defined Terms

This section:
- Defines the terms used throughout this SPD.
- Is not intended to describe Benefits.

Alternate Facility - a health care facility that is not a Hospital, or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services.
- Emergency Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or revised provisions or Benefits to the Plan. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

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Annual Deductible - the amount you must pay for Covered Health Services in a calendar year before we will begin paying for Benefits in that calendar year.

Benefits - your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this SPD and any applicable Riders and Amendments.

Care Coordination^{SM} - a program provided by the Claims Administrator designed to encourage an efficient system of care for Covered Persons by identifying and addressing possible unmet covered health care needs.

Claims Administrator - the company, or its affiliate, that provides certain claim administration services for the Plan.

Congenital Anomaly - a physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Copayment - the charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by Care Coordination^{SM} on our behalf.

Covered Health Service(s) -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not

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Covered--Exclusions), including Experimental or Investigational Services and Unproven Services.

Covered Health Services must be provided:

- When the Plan is in effect;
- Prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Covered Person - either the Participant or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Participant's legal spouse or an unmarried Dependent child of the Participant or the Participant's spouse,

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including a surviving spouse, if such spouse remains unmarried from the time of the Employee's or Retiree's death. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A Handicapped Child, as described in (Section 8: When Coverage Ends).
- A child for whom legal guardianship has been awarded to the Participant or the Participant's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any unmarried Dependent child under 19 years of age.
- A Dependent includes an unmarried Dependent child who is 19 years of age or older, but less than 25 years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - — The child must not be regularly employed on a full-time basis.
  - — The child must be a Full-time Student.
  - — The child must be primarily Dependent upon the Participant for support and maintenance.

The Participant must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

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A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order, including a National Medical Support Notice. We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order or a National Medical Support Notice.

Designated United Resource Network Facility - a Hospital that the Claims Administrator names as a Designated United Resource Network Facility. A Designated United Resource Network Facility has entered into an agreement with the Claims Administrator to render Covered Health Services for the treatment of specified diseases or conditions. A Designated United Resource Network Facility may or may not be located within our geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated United Resource Network Facility.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.

Eligible Expenses - the amount we will pay for Covered Health Services, incurred while the Plan is in effect, which are determined as stated below:

Eligible Expenses are based on either of the following:

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- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers, unless you receive services as a result of an Emergency, Eligible Expenses are determined at the Claims Administrator's discretion by either (1) calculating Eligible Expenses based on available data resources of competitive fees in that geographic area, or (2) applying the negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors.

Eligible Expenses are determined solely in accordance with the Claim Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claim Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Eligible Person - a regular full-time Employee of the Plan Sponsor who is scheduled to work at his or her job at least 20 hours per week or otherwise considered by the Plan Sponsor to be an Employee for

To continue reading, go to left column on next page.

Plan coverage purposes; or a person who retires while covered under the Plan.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Employee - an Eligible Person who is properly enrolled under the Plan. The Employee is the person (who is not a Dependent) on whose behalf the Plan is established.

Enrolled Dependent - a Dependent who is properly enrolled under the Plan.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.

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- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Full-time Student - a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, beautician school automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student at the end of the calendar month you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

To continue reading, go to left column on next page.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law, that is both of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time, as determined by the Plan Administrator, during which Eligible Persons may enroll themselves and their Dependents under the Plan.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

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Maximum Plan Benefit - the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Plan, or any other Plan of the Plan Sponsor. When the Maximum Plan Benefit applies, it is described in (Section 1: What's Covered--Benefits).

Medicare - Parts A, B, and C of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Abuse Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available under the Plan.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect with the Claims Administrator or an affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case,

To continue reading, go to left column on next page.

the provider will be a Network provider for the Health Services and products included in the participation agreement, and a non-Network provider for other Health Services and products. The participation status of providers will change from time to time.

Network Benefits - Benefits for Covered Health Services that are provided by a Network Physician or other Network provider.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Plan. The Plan Administrator will determine the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - the maximum amount you pay out-of-pocket every calendar year after the Annual Deductible is met. If you use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Depending on the geographic area and the service you receive, you may have access to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, your Coinsurance for Non-Network Benefits will remain the same, however the total amount that you owe may be less than if you received services from other non-Network providers because the Eligible Expenses may be a lesser amount.

Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.

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- Copayments for Covered Health Services available by an optional Rider.
- Any Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.
- The amount of any reduced Benefits if you don't notify Care Coordination℠ as described in (Section 1: What's Covered--Benefits) under the *Must You Notify Care Coordination℠?* column.
- Charges that exceed Eligible Expenses.
- Any amounts applied towards meeting your Annual Deductible.

Even when the Out-of-Pocket Maximum has been reached, the following will not be paid at 100%:

- Any charges for non-Covered Health Services.
- The amount of any reduced Benefits if you don't notify Care Coordination℠ as described in (Section 1: What's Covered--Benefits) under the *Must You Notify Care Coordination℠?* column.
- Charges that exceed Eligible Expenses.

Participant - an Eligible Person who is properly enrolled under the Plan. The Participant is the person (who is not a Dependent) on whose behalf the Plan is established.

Physician - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that

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Benefits for services from that provider are available to you under the Plan.

Plan - United HealthCare Out of Area Plan for Cinergy Corp. Health Benefit Plan.

Plan Administrator - is the Cinergy Corp. or its designee as that term is defined under ERISA.

Plan Sponsor - Cinergy Corp.. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Retiree - any person who retires from Cinergy and is determined and approved by the Plan Sponsor to be eligible to receive coverage under the Plan as a Retiree.

Rider - any attached written description of additional Covered Health Services not described in this SPD. Riders are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

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Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Spinal Treatment - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and the Claims Administrator may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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RIGHT HAND PAGE

Riders, Amendments, Notices

Attachment I

Attachment II

Attachment I

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

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Statement of Rights under the Newborns' and Mothers' Health Protection Act

Group health Plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require than a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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Attachment II

Summary Plan Description

Name of Plan: Cinergy Corp. Health & Welfare Benefits Plan, as it relates to the United HealthCare Out of Area Plan for Cinergy Corp; Group Number 239203

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Cinergy Corp.
139 East Fourth Street
Cincinnati, OH 45202
(513) 287-3333

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Employer Identification Number (EIN): 31-1385023

IRS Plan Number: 506

Effective Date of Plan: January 1, 2004

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Type of Plan: Self-insured health and welfare benefits plan, offering group health plan benefits to Employees, Retirees and their Dependents

Name, Business address, and Business Telephone Number of Plan Administrator:

Cinergy Corp.
139 East Fourth Street
Cincinnati, OH 45202
(513) 287-3333

Claims Administrator: The following entity provides certain administrative services for the Plan.

United HealthCare Insurance Company
450 Columbus Blvd.
Hartford, CT 06115-0450

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of Benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Sponsor also has selected a Provider Network established by United HealthCare Insurance Company. The named fiduciary of Plan is Cinergy Corporation, the Plan Sponsor.

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Person designated as agent for service of legal process: Service of process may also be made upon the Plan Administrator.

Source of contributions under the Plan: There are no contributions to the Plan. All Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required Participant contributions are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

Method of calculating the amount of contribution: Participant-required contributions to the Plan Sponsor are the Participant's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required Participant contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to Participants.

Date of the end of the year for purposes of maintaining Plan's fiscal records: Plan year shall be a twelve month period ending December 31.

Determinations of Qualified Medical Child Support Orders.

The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Although the Plan Sponsor currently intends to continue the Benefits provided by this Plan, the Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add Benefits or terminate this Plan or this Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or Amendment to or termination

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of the Plan, its Benefits or its terms and condition, in whole or in part, shall be made solely in a written Amendment (in the case of a change or Amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The Amendment or resolution is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or Amendments to the Plan.

Benefits under the Plan are furnished in accordance with the Plan Description issued by the Plan Sponsor, including this Summary Plan Description.

Participant's rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the procedures to be followed in regard to denied claims or other complaints relating to the Plan are set forth in the body of this Summary Plan Description.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S.

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Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another group health Plan. In addition, if your Plan coverage ceases, you have the right to be provided a certificate of creditable coverage, free of charge, from the Plan, as well as any other group health plan or health insurance issuer when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. You should know that, currently, the Plan does not impose any pre-existing condition limitations or exclusions.

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Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court after all required reviews of your claim have been completed. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the

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U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Pension and Welfare Benefits Administration.

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