Cingular Wireless Medical Plan
for
Bargained Employees

Including
Prescription Drug
And
Behavioral Health
(Formerly known as Mental Health/Chemical Dependency)
Programs

Summary Plan Description

This “Summary Plan Description” or “SPD” is effective for claims incurred on or after January 1, 2007. For claims incurred prior to that date, the SPDs dated January 1, 20065 or earlier, as applicable, together with any “Summaries of Material Modification” or “SMMs” shall govern.

NIN:78-11228

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Overview

This "Summary Plan Description" or "SPD" is effective for claims incurred on or after January 1, 2007. For claims incurred prior to that date, the SPDs dated January 1, 2006 or earlier, as applicable, together with any "Summaries of Material Modification" or "SMMs" shall govern.

This Summary Plan Description ("SPD") is a brief description of the Cingular Wireless Medical Benefits for Bargained Employees ("Medical Plan"). Consult the ***Eligibility, Enrollment And Other Administrative Provisions*** section of the SPD for information about plan eligibility, enrollment and other plan administration details. This SPD does not attempt to cover all the details. Specific details are included in the Cingular Wireless Health and Welfare Benefits Plan for Bargained Employees ("Plan Document"), which regulates the operation of the Plan. The Plan Document legally governs the operation of the Plan, and is the final authority on the terms of the Plan. The *Other Important Information* section also contains important information about the Medical Plan. You should read that section in conjunction with this SPD.

The Medical Plan of the *Cingular Wireless Bargained Employees Health and Welfare Benefit Plan* provides coverage for Medically Necessary covered health care services including prescription drug and behavioral health benefits. The Medical Plan is designed to help control health care costs and to involve employees in health care purchasing decisions, by providing choices and the opportunity for employees to take a more active role in their own health care. The Medical Plan also promotes wellness and protects employees from catastrophic risk without automatically shifting costs to employees. If you or your eligible Dependent(s) are enrolled in an EPO option, please refer to the Summary Plan Description for that option.

The Plan includes two benefit groups: National Bargained Health Plan Medical Benefits and SNET Retiree Medical Benefits. Please consult the Eligibility, Enrollment and Other Administrative Provisions section of the SPD to determine your group. These different programs are described in detail later in this SPD.

Cingular Wireless LLC ("Company") intends to continue this Medical Plan indefinitely but reserves the right, subject to applicable collective bargaining agreements, to terminate, amend, change or modify the Medical Plan, retroactively or prospectively, in full or in part at any time or for any reason, including changes in any or all of the benefits provided. See the *Other Important Information* section for more information regarding Plan amendment and termination.

Contact Information

Cingular Benefit Service Center:

Telephone: 1-877-421-5225
Cingular Wireless Intranet Site: My Cingular/Human Resources/ NetBenefits
Internet: http://netbenefits.fidelity.com

Claims Administrators

Point Of Service and Out Of Area Options Claims Administrator and Care Coordination:
United HealthCare
PO Box 740800
Atlanta, GA 30374-0800
Telephone: 1-866-501-3068
TDD: 1-800-545-6751
www.myuhc.com

Behavioral Health Program Claims Administrator:
United Behavioral Health
PO Box 740800
Atlanta, GA 30374-0800
Telephone: 1-800-538-8101
TDD: 1-800-842-9489
www.liveandworkwell.com (access code: Cingular)

Prescription Drug Program Claims Administrator:
Caremark Prescription Services
7034 Alamo Downs Parkway
San Antonio, Texas 78238
Telephone: 1-800-388-2085
www.caremark.com

Definitions

Congenital Heart Disease Program

The Congenital Heart Disease ("CHD") program is the Claims Administrator's program made available under Cingular's medical plans to covered Employees. The Congenital Heart Disease Program provides information to Employees or their Covered Dependents with congenital heart disease and offers access to additional centers for the treatment of congenital heart disease. (More information is provided in subsequent sections of this SPD.)

Covered Health Services

Covered Health Services are 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 Covered Services as a Covered Health Service and which is not excluded under Exclusions and Limitations, including Experimental or Investigational Services or Therapies and Unproven Services.

Covered Health Services must be provided:
- When the Medical Plan is in effect;
- Prior to the effective date of termination of an individual's coverage; and
- Only when the person who receives services is a covered person and meets all eligibility requirements of the Medical Plan.

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

Educational or Developmental

"Educational” or “Developmental" means that the primary purpose of a service or supply is to provide the participant with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation of an occupation; or treatment for learning disabilities, or the service or supply is being provided to promote development beyond any level of function or development previously demonstrated by the participant. "Training in the activities of daily living" does not include training directly related to, treatment of an illness or injury that resulted in the loss of a previously demonstrated ability to perform those activities, In the case of a hospital stay, the length of the stay and the hospital services and supplies are not covered to the extent that they are determined to be allocated to the scholastic education or vocational training of the patient.

Experimental or Investigational Services or Therapies

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

- Not approved by the U. S. Food and Drug Administration 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 proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial as set forth in the FDA regulations regardless of whether the trial is actually subject to FDA oversight.

Medically Necessary

The treatment provided by your doctor or provider deemed to be necessary for preventive care or the diagnosis and treatment of a medical or dental condition and provided based on generally accepted medical or dental practice. The Medically Necessary determination made by the Claim Administrator may limit your benefits.

Reasonable and Customary; R&C

The fees charged by your doctor or the provider to the majority of patients for a similar service that fall within the range of usual fees charged by doctors or providers with similar training and experience for the same or similar service with the same geographical area. The Reasonable and Customary determination made by the Claim Administrator may limit your benefits.

Reconstructive Procedure

Reconstructive Procedure: Means a procedure whose primary purpose is to improve or restore physiologic function to an organ or body part which has a physical impairment; that is to make the target organ or body part work better and the procedure is not a cosmetic procedure.

Unproven Services

Unproven Services are 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.)

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.

Common Terms

Certain terms used in this SPD beginning with a capital letter (such as Employee or Dependent) are defined in the Eligibility, Enrollment and Other Administrative Provisions section. The Plan Document legally governs the operation of the Plan and is the final authority on the meaning of the terms of the Medical Plan.

Eligibility

See the Eligibility, Enrollment and Other Administrative Provisions section.

Enrollment and Effective Dates

See the Eligibility, Enrollment and Other Administrative Provisions section.

Annual Enrollment

See the Eligibility, Enrollment and Other Administrative Provisions section.

Changes in Coverage or Enrollment

See the Eligibility, Enrollment and Other Administrative Provisions section.

Contributions

See the Eligibility, Enrollment and Other Administrative Provisions section.

When You Take A Leave Of Absence

See the Eligibility, Enrollment and Other Administrative Provisions section.

When You Are Disabled

See the Eligibility, Enrollment and Other Administrative Provisions section.

If You Die

See the Eligibility, Enrollment and Other Administrative Provisions section.

When Coverage Ends

See the Eligibility, Enrollment and Other Administrative Provisions section.

Conversion

All bargaining units have a medical conversion option. At termination of coverage an employee and covered Dependents have the option to apply for an individual contract with the designated carrier if the employee is not eligible for Medicare, is not eligible for COBRA continuation coverage, has elected not to continue coverage for COBRA or has completed COBRA continuation. An employee can only convert if he or she was enrolled in the plan at the time of termination. There will be a conversion fee for a basic medical policy and for a major medical policy. **The employee must pay the conversion fee.**

How to File a Claim

Claims Procedures

Claims should be submitted no later than 90 days after the end of the calendar year in which the medical services were provided.

You must file a claim to receive benefits for Non-Network or OOA care. You don't need to file a claim for services provided by or referred in writing by your PCP. Medical Claim forms are available from the Claims Administrator.

You must complete a Medical Claim form each time you submit a claim. Claims must be filed within a year of the date of service if the Medical Plan is your only medical coverage, or within two years if your claim for benefits is coordinated with other coverage, such as Medicare. Prescription Drug Claims and Mental Health/Chemical Dependence claims are subject to the same time limitation. Multiple claims submitted for the same individual can be submitted on one claim form.

To file a claim, follow the steps shown below. Be sure that the following information is on each claim form and/or itemized bill:

- Employee's name;
- Employee's Social Security number
- Patient's name, date of birth, and relationship to the employee;
- Information about any other coverage you or a Dependent has under another insurance policy;
- Authorization for your physician, dentist, hospital, or other provider to release necessary information to the insurance company so it can process your claim;
- Name of provider of service;
- Diagnosis;
- Dates of service;
- Nature of the service or supplies; and
- Charges.

For Non-Network or OOA claims, if you assign benefits, the provider of service will receive the benefits payment. Keep in mind that you must also pay a portion of the total expenses you incurred.

If you do not assign benefits for Non-Network claims, you'll receive the benefits payment. It is then your responsibility to pay the physician or other provider of service.

One Year Claim Filing Limitation

Claims must be filed within a year of the date of service. Claims submitted past the filing date will not be considered for reimbursement.

If Your Claim is Denied

If a claim for benefits is denied, either in whole or in part, you or your Dependents have the right to appeal the decision. See the *Other Important Information* section.

When Your Claim Is Processed

For each claim you submit, you will receive an Explanation of Benefits (EOB) from the Claims Administrator. This statement shows what benefits were paid, who received the payment, and how benefits were calculated. If you receive benefits, you will receive a check and an EOB. If you assign benefits or if no benefits are payable, you will still receive an EOB. Retain the EOB for your records. You will need to include copies of EOBs if you have medical coverage from more than one provider and will be filing coordination of benefits claims.

Coordination of Benefits

See the Eligibility, Enrollment and Other Administrative Provisions section.

Overpayment

See the Eligibility, Enrollment and Other Administrative Provisions section.

Right of Recovery

See the Eligibility, Enrollment and Other Administrative Provisions section.

Unclaimed / Uncashed Benefit Payments

See the Eligibility, Enrollment and Other Administrative Provisions section.

Plan Administration

See the Eligibility, Enrollment and Other Administrative Provisions section.

Your Rights Under ERISA

As a participant or a Dependent of a participant in the Medical Plan, you have rights under the Employee Retirement Income Security Act (ERISA). For more information, see the *Other Important Information* section.

How To File An Appeal

See the *Other Important Information* section.

Special Notices

The following notices apply to each of the bargaining units' medical plans described in this SPD.

Newborns' and Mothers' Health Protection Act of 1996

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 if applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act was signed into law in 1998. The law includes important protections for breast cancer patients who seek breast reconstruction after undergoing a mastectomy. Specifically, the medical plan participant who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction will be provided with coverage for services determined by the attending physician and the patient which include:

- 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 at all stages of the mastectomy, including lymphedemas.

For more information regarding specific coverage levels, refer to the coverage provisions. If you have elected EPO coverage, please contact your EPO for more information.

Organ and Tissue Transplants

This program is part of each of the bargaining units' plans described in this SPD.

United Resource Network

The United Resource Network consists of selected hospitals and physicians that have demonstrated expertise in performing specific procedures or treatments while maintaining high standards of care. The Claim Administrator thoroughly reviews the experience and capabilities of each facility before selecting it as a **("**United Resource Network Facility").

Each United Resource Network Facility has agreed to furnish services and supplies for one or more of the Plan's procedures under the terms of an agreement with the Claim Administrator. Charges for the services under the agreement are reimbursed on the basis of a negotiated fee. The negotiated fee is generally lower than the United Resource Network Facility's usual charge for other patients.

Transplantation Services

Covered Services

Covered Health Services include the following organ and tissue transplants when ordered by a physician. For Network Benefits, transplantation services must be received at a United Resource Network Facility. Out of Network benefits are available at a facility approved by the Claims Administrator. 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.

Claims Administrator notification is required for all transplant services.

The following are qualified procedures under the United Resource Network program:

- Heart Transplants
- Lung Transplants
- Heart/Lung Transplants
- Liver Transplants
- Small Bowel Transplants
- Liver/Small Bowel Transplants
- Kidney Transplants
- Pancreas Transplants
- Kidney/Pancreas Transplants
- Bone marrow/Peripheral Stem Cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. 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.
- Other transplant procedures when the Claims Administrator determines that it is appropriate to perform the procedure at a United Resource Network Facility.
- Treatment for Congenital Heart Disease ("CHD")
    - You must notify the Claims Administrator as soon as CHD is suspected or diagnosed (in utero detection, at birth, or as determined and before the time an evaluation for CHD is performed).

Benefits are also available for Cornea Transplants that are provided by a Physician at a Hospital. Cornea Transplants do not need to be provided at a United Network Facility in order to receive Network Benefits.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage.

Under the Plan there are specific guidelines regarding benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

United Resource Network and Travel and Lodging Benefit

The Medical Plan provides access to the Claim Administrator's United Resource Network and Travel and Lodging Benefit. This voluntary program guides patients to selected hospitals for organ transplants and other technologically advanced medical procedures. This voluntary program is available to you through the PPO or OOA options.

The Medical Plan pays 100% of your eligible charges at a United Resource Network Facility, and eligible travel expenses to and from the United Resource Network Facility. The Medical Plan also pays 100% of a travel companion's eligible travel and hotel expenses, up to $10,000 per procedure.

Referral to a United Resource Network Facility

You or your physician may elect to use the services of, and initiate the referral to, a United Resource Network Facility. In order to initiate a referral, contact the Claim Administrator. You will receive a listing of the participating United Resource Network Facilities. The listing will include the facility's name, address, telephone number and the procedures(s) for which the facility is participating in the program.

The United Resource Network Facility you select is subject to approval by the Claim Administrator. This approval is called a referral and is your authorization to use the United Resource Network Facility and provides access to the Travel and Lodging Benefit benefits. Unless otherwise approved, the United Resource Network Facility in which the procedure will be performed is the one that is nearest to your home.

The United Resource Network Facility will perform a pre-screening evaluation to determine that the treatment procedure is appropriate. Once the treatment procedure is approved at the United Resource Network Facility, the Claim Administrator will contact both the patient and the travel companion in order to coordinate the travel and lodging arrangements.

Out of Network Benefits

For covered transplants at other than United Resource Network Facilities, the normal provisions of the POS or OOA options will apply. The patient and companion Travel and Lodging Benefit will not apply. Notification through the Claims Administrator is required.

Treatment received at a United Resource Network Facility without a referral will be paid at normal coinsurance levels and no patient or companion travel and lodging benefits will be paid.

Using the United Resource Network With a Referral

If you elect to use and are approved for the United Resource Network program, the Medical Plan pays 100% of the eligible charges for:

- the health care services and supplies, and
- your transportation to and from the United Resource Network Facility.

Travel and Lodging Benefit

Under the Travel and Lodging Benefit, the Plan pays benefits for some of the charges incurred by a travel companion to accompany you to a United Resource Network Facility. It also pays benefits for some of the charges a travel companion incurs to remain with you for all or a portion of your stay in the United Resource Network Facility. Not all charges are eligible; some are excluded entirely or included to a limited extent:

- The United Resource Network Facility must be located 50 or more miles from the travel companion's home.
- The travel companion's itinerary must be approved by the Claim Administrator before any charges are incurred. Itinerary includes mode of transportation and hotel accommodations.
- There are Travel and Lodging Benefit maximums and limits which apply to your stay at a United Resource Network Facility.

- A service or supply which is a Travel and Lodging Benefit service or supply will be considered for coverage under the Plan if included in the list of eligible services and supplies provided to you and your travel companion by the Claim Administrator.
- A charge is an eligible charge under the Travel and Lodging Benefit if it is for a service or supply that is furnished while the travel companion is accompanying you to or from a United Resource Network Facility or while you are confined at a United Resource Network Facility.

The Plan pays 100% of the eligible charges under the Travel and Lodging Benefit, up to the limits shown below. Travel plans and other eligible charges must be submitted to the Claim Administrator for review prior to travel.

Transportation – There is an eligible charge limit for each trip to a United Resource Network Facility. That limit is the amount equal to the cost of a round trip coach air fare to the United Resource Network Facility. If your stay at a United Resource Network Facility is for three or more weeks, the limit will be the cost of two round trip coach air fares to the United Resource Network Facility. These limits apply whether the transportation is as a passenger on a public vehicle provided by a common carrier for passenger service or while using a motor vehicle. For transportation to the United Resource Network Facility while using a motor vehicle, the amount payable is equal to the current IRS mileage reimbursement rate per mile to the United Resource Network Facility, up to the limit described above. Mileage will be determined by the Claim Administrator in accordance with the most current edition of the Rand McNally guide.

Hotel Accommodations – Hotel accommodations necessary for a travel companion to remain in the immediate area of the United Resource Network Facility for all or a portion of the patient's stay are covered. There is a hotel accommodation daily eligible charge limit for charges incurred for each day of a travel companion's stay not to exceed $75 per day.

Other Eligible Charges – Other reasonable and necessary services and supplies furnished to a travel companion are covered, such as meals and other related expenses approved by the Claim Administrator. A claim must be submitted with receipts for these charges. There is a daily limit of $25 per day.

Ineligible Charges – In addition to those expenses listed in the *Expenses Not Covered* section certain United Resource Network Facility and Travel and Lodging Benefit expenses are not covered, including, but not limited to, the following:
- Charges for personal comfort and convenience items;
- Charges that are not incurred during the patient's stay at an United Resource Network Facility, except travel days;
- Charges that have not been included in the patient's or the travel companion's itinerary as approved by the Claim Administrator;
- Charges in connection with transportation for the patient other than the trip to and/or from the United Resource Network Facility, except as approved by the Claim Administrator;
- Charges in connection with transportation for the travel companion other than the trip required to accompany the patient to and/or from the United Resource Network Facility, except as stated in the Travel and Lodging Benefit section above;
- Charges in connection with the repair or maintenance of a motor vehicle;
- Charges for personal expenses incurred by the travel companion to maintain the patient's or the travel companion's home during the patient's stay at the United Resource Network, including child care charges, house-sitting charges and kennel charges; and

- Reimbursement of any wages lost by the patient or the travel companion during the patient's stay at the United Resource Network.

Congenital Heart Disease Resources Program

Covered Services

The Plan pays Benefits for Congenital Heart Disease ("CHD") services ordered by a Physician and received at a CHD Resource Services program. Benefits are available for the following CHD services:

- Outpatient diagnostic testing;
- In Utero Services;
- Evaluation;
- Surgical interventions;
- Interventional cardiac catheterizations (insertion of a tubular device in the heart);
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact the Claims Administrator for information about CHD services.

The Claims Administrator must be notified before treatment and as soon as CHD is suspected or diagnosed in order for the services to be covered under the Plan. Treatment received at a CHD Network Facility without a referral will be paid at normal coinsurance levels and no patient or companion travel and lodging benefits will be paid.

If you elect to use and are approved for the Congenital Disease Program, the Medical Plan pays 100% when CHD service is received at a Congenital Heart Disease Resource Services program. The services described under the Transplantation Transportation and Lodging are Covered Health Services ONLY in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Travel and Lodging Benefit

The services described under Travel and Lodging for Transplant Services (above) are also Covered Health Services in connection with CHD services only if received at a CHD Resource Services program.

Benefits – National Bargained Health Plan – Medical Plan

National Bargained Group Employees and Retirees (See Eligibility, Enrollment and Other Administrative Provisions of the SPD)

Overview

The Company offers the following types of healthcare options:

- Point of Service ("POS") option
- Out Of Area ("OOA") option
- Managed Care Alternatives to plan Coverage
  - Exclusive Provider Organization ("EPO") option

The POS and EPO options are available in certain geographic areas. If you live in a zip code area serviced by a POS and/or EPO, you can enroll in only one of these options. The OOA is available only for Employees or Retirees who do not live in an area serviced by the POS option. Employees who enroll in the POS, EPO or OOA option are automatically enrolled in the Prescription Drug component of this Medical Plan. Employees who enroll in the POS or OOA option are automatically enrolled in the Behavioral Health component of this Medical Plan.

If you elect coverage with EPO option, as an alternative to coverage under the Plan, you are subject to the benefits, terms and limitations of that option, including that option's claims appeal process. For more information about these options, contact them for a copy of their insurance certificate/booklet or SPD. These options are not described in this booklet.

Coverage under the Plan is not automatic. You must enroll when notified by the Company.

The Medical Plan provides different levels of benefits depending on whether or not you live within a Network area. You are automatically eligible for Network benefits if you live within a Medical Plan Network area based on your home address zip code.

You receive Network benefits through the POS option when you coordinate your care through a Primary Care Physician ("PCP") whom you select. If you choose not to use a PCP, you are eligible for non-Network benefits.

If you live outside a POS Network area, you are eligible for the OOA option. However, you and your Dependents may elect at any time to enroll in the POS option. If you elect to enroll in the POS, you can elect to return to the OOA option only during a subsequent annual enrollment period. Please contact the **Cingular Wireless Benefits Service Center** for more information.

The Claims Administrator is responsible for management of the POS Network and for the determination of Network, Non-Network and OOA option benefits (other than benefits available under the programs for behavioral health care and prescription drugs). Regardless of whether you live in or outside a POS Network area, the Medical Plan also provides benefits for behavioral health care and prescription drugs.

Many types of providers are covered by the behavioral health care program. Maximum benefits are received when you use the program's participating providers. Benefits may also vary depending on whether care is provided as an inpatient or as an outpatient. See the *Behavioral Health Care* section for more information.

You may purchase prescription drugs using a prescription card at a participating pharmacy or have them delivered to your home through the mail order program. See the *Prescription Drugs Section* for more information about the retail and mail order programs.

Coverage is not automatic. To have coverage under the Medical Plan, you must enroll.

Plan Details

The following applies to all Plan benefits, except for services and supplies provided through the Behavioral Health and Prescription Drug programs. You can receive Non-Network or OOA benefits only for Covered Health Services approved by a doctor or other qualified medical care provider. Care must be provided by a provider who meets the definitions under the Medical Plan. Expenses must be Medically Necessary for the diagnosis and treatment of a medical condition, including pregnancy, and provided based on generally accepted medical practice.

Care cannot be for the convenience of the patient or the provider and cannot be Educational, Developmental, Experimental or Investigational Services or Therapies. Care also must be the most appropriate needed to provide safe and adequate care.

Network care coordinated through a primary care physician for covered medical expenses is considered a Covered Health Service. This does not apply to care provided under the behavioral health program.

Payments for Covered Health Services are based on the actual charges of the provider. However, the Medical Plan will only consider for payment the lesser of the provider's charges or the R&C for services and supplies in a geographic area.

Any portion of the covered non-Network or OOA expense that is above the R&C is an ineligible expense and will not be reimbursed.

Expenses above the R&C are considered non-covered expenses and do not count toward your deductible or out-of-pocket maximum. For example, if a physician's fee is $100 and the Claims Administrator determines that $80 is the reasonable and customary charge for the service, the charge considered for payment is $80. The excess ... $20 in this case ... does not count toward the deductible or out-of-pocket maximum, and payment will be your responsibility.

Network and Non-Network Areas

Your eligibility for Network area benefits depends on your home address zip code as it is listed on the Company's payroll records. You can review this information by checking the address and zip code listed on your current pay stub.

If you are in a Network area or elect into Network area benefits from outside the Network area, you may choose how to receive your care each time you need it.

- **Network Care** - You must have your care coordinated by a primary care physician ("PCP") who is a member of the POS Network.
- **Non-Network Care** -You may choose to be treated by any physician.

Either way, you receive benefits from the Medical Plan, but you receive a greater level of benefits when your care is managed by your PCP.

Network providers contract with the Claims Administrator to provide medical services for set fees and agree to adhere to specific quality management requirements. Because the providers agree to a specific fee structure for a certain period of time, networks provide the opportunity to stabilize costs.

If you have any questions or concerns regarding a POS Network provider, or would like to request more information about the providers in your Network area, please contact the Claims Administrator.

When your PCP manages your medical care, your medical benefits are different than if you used a non-Network provider.

For instance:

- *You do not* have to satisfy a calendar-year deductible before you receive benefits;
- You pay only a small copay for each doctor office visit;
- Your company pays most of the rest of your expenses; and
- You can receive benefits for preventive care such as routine health assessments and immunizations from your PCP.

You **must select and use a POS PCP to receive Network medical benefits.** You may change your PCP at any time.

The first step in using the POS Network is to choose a PCP. Each enrolled family member must select a PCP (each may select a different PCP). You may choose your PCP from any of the internists, pediatricians, family practitioners or general practitioners in the POS Network. Each female family member may also select an OB/GYN as her secondary PCP for care that is obstetrical or gynecological related.

Generally, as long as your PCP coordinates your medical care, you are eligible for the POS Network benefits. The exceptions would be care provided by your POS Network OB/GYN, chiropractor or podiatrist. Chiropractors and podiatrists must contact the Claims Administrator for authorization after the first visit.

You receive Network benefits when Your PCP manages your care. For instance:

- Routine and preventive care must be provided by or authorized by your PCP;
- Your PCP will coordinate with the Claims Administrator for any hospitalizations;
- Your PCP will refer you to the Medical Plan Network specialty care physicians when appropriate;
- The Network specialty care physician must coordinate any hospitalizations with your PCP and the Claims Administrator; and

- Your OB/GYN may also refer you for specialty care, but only for obstetrical or gynecological related diagnosis or treatment.

You may select or change your PCP, by contacting the Claims Administrator.

You may choose to obtain certain types of care through your PCP and other types of care through a non-network physician. It's your choice each time you need medical care. This does not apply to services and supplies provided under the behavioral health program as outlined in the *Behavioral Health* section.

When you do not coordinate your care through your PCP, your medical expenses are still covered by the Medical Plan, but at the non-Network benefit level. For example:

- You must satisfy an annual deductible before your expenses are eligible for reimbursement;
- After the deductible is met, the Medical Plan generally pays 80% of the R&C expenses;
- You must file claim forms to receive reimbursement. See *How To File A Claim* for more information; and
- You must initiate and follow pre-certification procedures by calling the Claims Administrator before you enter the hospital and/or have surgery to receive full benefits. See *Non-notification Penalty*.

Each time you need medical care, you decide the level of benefits you receive, because you make the choice to use your local POS Network or not. That same choice is made, and it can be different from yours, for each covered family member each time one of them needs medical care.

Your local POS Network operates within a specific geographic area. To receive Network benefits within your Network area you should always contact your PCP first. Your PCP or his or her covering physician can be reached 24 hours a day. However, in a life-threatening medical emergency, seek care immediately and then notify your PCP within 24 hours for authorization of the emergency treatment.

If you are traveling or temporarily reside outside your Network area and need care, you do not have to contact your PCP. However, in order to receive Network benefits, you must contact the Claims Administrator listed on your Medical Plan identification card each time you require medical care.

If the Claims Administrator has a Network in the area, you will be referred to a Network provider and will receive Network benefits.

If the Claims Administrator does not have a Network in the area, you will be directed to seek care from a qualified provider. You will receive Network benefits if you follow the instructions given by the Claims Administrator. You must file a claim for reimbursement of these expenses. Claim forms are available from the Claims Administrator.

If you do not contact the Claims Administrator for authorization, then you will receive Non-Network benefits.

Generally, if you live in a Network area or elect to join a Network area, your Dependents are eligible for Network area benefits. However:

IF YOU LIVE IN A NETWORK AREA AND YOUR DEPENDENT LIVES...	THEN...
Temporarily or permanently in another POS Network area...	Your Dependents are eligible for Network benefits if they elect into and select a PCP in that POS Network area. To elect your Dependent into a POS Network area different from your own, please contact Claims Administrator.
Temporarily outside any POS Network area...	Your Dependents are eligible for Network benefits • if they choose and use a PCP in your POS Network area, or • if they contact the Claims Administrator listed on their Medical Plan ID card each time that medical care is required, • AND if they follow the instructions given by the Claims Administrator. Be sure to record the authorization number provided by the claims administrator. You must file a claim for reimbursement of these expenses.
Permanently outside any POS Network area...	Your Dependents are eligible for the POS Non-Network area benefits that are described below.

Benefits Summary

Deductibles

Network Benefits
There is no calendar-year deductible that you must pay before you can receive Network benefits. However, certain types of Network care (i.e., doctor's office visits, emergency room visits and inpatient hospital admissions) require that you pay a copay at the time services are provided. These copays do not count toward the non-Network deductible.

Non-Network Benefits
For non-Network care, you first pay the deductible before you receive any benefits. Emergency room visit copays, inpatient hospital admission copays do not count toward your deductible.

Satisfying the Deductible
The following expenses cannot be used to satisfy the deductible:
- Copays
- Out-of-pocket drug expenses
- Penalties
- Behavioral health expenses; and,
- Non-covered charges

Family Deductible

- All family members may contribute toward the three or more person deductible. However, no person may contribute more than the individual amount.
- Only one individual deductible will apply for benefits resulting from an accident involving two or more covered family members.

End of Year Expenses

Any expenses incurred by employees in the last three months of the year and applied to that year's deductible may be reused to meet the deductible in the next calendar year.

Copays and Coinsurance

Network Benefits

The POS option typically pays 100% of the cost of covered medical expenses for Network care. Therefore, there is no coinsurance. For certain types of Network care (i.e., doctor's office visits, emergency room visits and inpatient hospital admissions), you pay a copay at the time services are provided, before the POS option pays 100% of your remaining costs.

Non-Network Benefits

After the calendar-year deductible is met, the Medical Plan generally pays 80% (of R&C) of the covered non-Network medical expenses. You pay the rest, up to the annual out-of-pocket maximum. The 20% you pay is called coinsurance.

Out of Pocket Maximums

Network Benefits

The POS option typically pays 100% of the cost of Covered Health Services for Network care. Therefore, there are no out of pocket maximums.

Non-Network Benefits

After the calendar-year deductible is met, the plans generally pay the coinsurance percentage of R&C of the covered benefits. You pay the remaining balance, up to the annual out-of-pocket maximum. This percentage is your coinsurance.

Satisfying the Out-of-Pocket Maximum

After your covered out-of-pocket expenses reach the non-Network out-of pocket maximum, the Medical Plan then pays 100% (of R&C) of your covered expenses for the balance of that calendar year. Only deductibles and coinsurance apply toward meeting the out-of-pocket maximum. The following expenses cannot be used to satisfy the out-of-pocket maximum:

- Copays
- Out-of-pocket drug expenses
- The difference between inpatient hospital-billed charges and the Medical Plan benefit
- Penalties
- Behavioral health expenses; and,
- Non-covered charges

Family Out-of-Pocket Maximum

- No one covered family member pays more than the individual out-of-pocket maximum.
- All family members may contribute toward the three or more person out-of-pocket maximum. However, no person may contribute more than the individual maximum amount, even if that person has had expenses in excess of the individual maximum amount.
- All covered family deductibles and coinsurance are combined to determine when a family reaches the three or more person out-of pocket maximum. In some cases, families with four or more covered members may meet the three or more person out-of-pocket maximum even if all family members have not reached the individual out-of-pocket maximum.
- Only one individual out-of-pocket maximum will apply for benefits resulting from an accident involving two or more covered family members.

Lifetime Maximum

There is an unlimited lifetime maximum for active employees and their Dependents. Retirees and their Dependents and recipients of long-term disability benefits have a $500,000 lifetime maximum per person for non-network charges.

Preventive Care

Network Benefits

For each doctor's office visit, you pay a copay per person. After you pay that copay, the Medical Plan pays 100% for newborn care, well child care, immunizations and other routine health assessments (including mammograms) approved or provided by your PCP or, if applicable, your OB/GYN.

You must enroll your newborns within 60 days of their birth in order to receive benefits under the Medical Plan.

Non-Network Benefits

Preventive care, not provided by your PCP or, if applicable, your OB/GYN, is not covered except as described under the *Schedule of Benefits* section.

Inpatient Care

Covered inpatient hospital care is subject to a copay per admission and includes hospital daily room and board (up to the regular semi-private room rate), general nursing care, intensive care and all the following inpatient services:

- Special diets;
- Routine nursery care of the newborn during the mother's post-delivery confinement (see *Newborn Care*);
- Operating, delivery, recovery and treatment rooms and equipment;
- All recognized drugs and medicines for in-hospital use;
- Dressings, ordinary splints and casts;
- X-ray exams, x-ray therapy, radiation therapy and treatment;
- Laboratory tests;

- Oxygen and oxygen therapy;
- Electrocardiograms and electroencephalograms;
- Physical therapy;
- Anesthesia;
- Processing and administering blood and blood derivatives if not replaced;
- Hemodialysis treatment;
- Chemotherapy;
- Electroshock therapy;
- Pre-surgical doctor consultations and in-hospital doctor visits (one consultation and one in-hospital doctor visit per day for non-Network); and
- Medical services for treatment of accidental injury which occurred while covered under the Medical Plan, or when a physician other than a dentist certifies that hospitalization for Medical treatment is Medically Necessary to safeguard the life or health of the patient because of the existence of a specified non-Medical organic impairment, such as heart trouble or hemophilia.

Certain inpatient services are not covered. See *Exclusions and Limitations* for a more detailed list.

Network Benefits

To receive Network benefits, your PCP must approve your hospital stay. For each hospital admission, you first pay the inpatient hospital copay. After you pay the copay per admission, the Medical Plan pays 100% of all eligible hospital charges.

Non-Network Benefits

For hospital admissions arranged by a non-Network physician and approved by the Claims Administrator, you must meet your calendar-year deductible and pay the inpatient hospital copay for each admission.

- For care in a Network hospital (i.e., not arranged by your PCP) - the Medical Plan pays 80% (of R&C) of the Covered Health Services. If your expenses reach the out-of-pocket maximum, the Medical Plan pays 100% (of R&C) of the remaining Covered Health Services for that calendar year.

- For care in a non-Network hospital - the Medical Plan pays the lesser of 80% of R&C or 100% of the average Network-negotiated fee. The difference between billed charges and the Medical Plan benefit will be considered non-covered charges and will not apply to the deductible and/or the out-of-pocket maximum.

Outpatient Care

The Medical Plan provides benefits for care as an outpatient. In many instances, you can avoid an overnight hospital stay by having a service or surgery performed as an outpatient at a hospital, a stand-alone ambulatory surgical facility or a doctor's office. The Medical Plan covers the following outpatient services:

- Surgery;
- Preadmission and diagnostic x-ray and laboratory tests including allergy testing;
- Hemodialysis treatment;
- Anesthesia;

- Chemotherapy and radiation therapy;
- Electroshock therapy;
- Emergency room treatment after you pay the copay per emergency room visit;
- Medical services for treatment of accidental injury which occurred while covered under the Medical Plan; or
- When a physician other than a dentist certifies that outpatient Medical treatment is Medically Necessary to safeguard the life or health of the patient because of the existence of a specified non-medical organic impairment, such as heart trouble or hemophilia.

Network Benefits

To receive Network benefits, your PCP must approve your outpatient care. If your PCP approves your outpatient care, the Medical Plan pays 100% of all eligible charges.

Non-Network Benefits

For non-Network care, you pay your calendar-year deductible. Then, the Medical Plan pays 80% (of R&C) of the covered expenses. If your expenses reach the out-of-pocket maximum, the Medical Plan pays 100% (of R&C) of the remaining covered expenses for that calendar year.

Newborn Care

The Medical Plan automatically covers the routine hospital nursery care of newborn children during the mother's post-delivery confinement.

Network Benefits

For routine care in a Network hospital during the mother's post-delivery confinement, the Medical Plan pays 100%.

Non-Network Benefits

After the calendar-year deductible is met, the Medical Plan pays 80% (of R&C) for one in-hospital pediatric exam of a newborn during the mother's post-delivery confinement.

For Coverage to Continue

Newborns must be enrolled within 60 days of their birth for coverage to be effective as of the day of their birth. It is your responsibility, to enroll your newborn by contacting the Cingular Wireless Benefits Service Center. You must select a PCP for your newborn.

Emergency Care

A medical emergency is an injury, illness or disease of such a nature that failure to get immediate medical care could be life threatening or cause serious bodily harm. Examples include apparent heart attack, severe bleeding, sudden loss of consciousness, convulsions, severe or multiple injuries and apparent poisoning.

In a medical emergency, whether inside or outside your Network area, seek medical care immediately. Then, contact your PCP or Claims Administrator number within 24 hours to ensure Network benefits.

If you are not admitted to the hospital, you pay a copay for each emergency room visit.

IF YOU SEEK CARE AT A HOSPITAL EMERGENCY ROOM...	THEN...
And the visit is to treat a condition that is a medical emergency...	You receive Network benefits regardless of the facility you use.
And the visit is to treat a condition that is not a medical emergency and you use a Network facility...	You receive Network benefits.
And the visit is to treat a condition that is not a medical emergency and you use a non-Network facility...	You receive non-Network benefits.

Network Benefits

You pay a copay for each emergency room visit. After the copay, the Medical Plan pays 100% of the cost of covered medical expenses for each emergency room visit. Network benefits will continue to apply to expenses related to the emergency if you inform your PCP or Claims Administrator of each emergency room visit within 24 hours.

If you are admitted to a hospital, the emergency room copay is waived.

Non-Network Benefits

You pay a copay for each emergency room visit. After the copay is paid and you meet your calendar-year deductible, the Medical Plan pays 80% (of R&C) of the covered medical expenses. If your expenses reach the out-of-pocket maximum, the Medical Plan pays 100% (of R&C) of the remaining covered expenses for that calendar year. If you are admitted to a hospital, the emergency room copay is waived.

Alternative Care

Alternative care is treatment in a facility other than a hospital, such as a birthing center, hospice, skilled nursing facility, or home health care. Alternative care is covered if it is in lieu of hospitalization as determined by your PCP or Claims Administrator. The Claims Administrator must approve all non-Network alternative care for it to be covered.

Network Benefits

If you coordinate your alternative care through your PCP, the Medical Plan pays 100% of the cost of the care. A 100-day annual combined Network and non-Network maximum applies to Network skilled nursing facility care.

Non-Network Benefits

After the calendar-year deductible is met, the Medical Plan pays 80% (of R&C) of the covered expenses. If your expenses reach the out-of-pocket maximum, the Medical Plan pays 100% (of R&C) of the remaining covered expenses for that calendar year.

Limitations on Non-Network Benefits

- Non-Network home health care is limited to 60 home health visits in a calendar year and a maximum benefit of $50 per visit.
- A 60-day annual combined Network and non-Network maximum applies to non-Network skilled nursing facility care.
- Non-Network benefits for hospice care are not available.
- No alternative care benefits are payable if you or your Dependents do not contact and follow Claims Administrator procedures.

Non-Notification Penalty

This provision applies to Non-network facilities or providers. You must contact the Claims Administrator for pre-certification before using a Non-network facility or provider for an inpatient admission, outpatient diagnostic procedure or certain surgeries. Failure to pre-certify will result in a reduction in benefit payments to 80% of the amount otherwise payable. This penalty cannot be used toward satisfaction of deductibles or out of pocket maximums. For non-emergency medical care outside your Network area, you must contact the Claims Administrator *each* time you seek medical care in order to receive coverage.

You must pre-certify the following surgical procedures or the non-notification penalty will be applied:

- Carpal Tunnel,
- Choleocystectomy
- Cardiac Catheterization
- Heart Surgery
- Hearth Catherization or Angioplasty
- Hip Replacement
- Hysterectomy
- Knee Arthoscopy
- Knee Replacement
- Laminectomy
- Spinal Fusion
- Pelvic Laproscopy
- Septoplasty
- Tonsillectomy/Adenoidecomy
- Myringotomy;
- Tympanostomy
- Nasal Endoscopy/Ethmoidectomy
- EDG—Endoscopic procedure of the Stomach or Intestine

Other Covered Services

For most Network services, the Medical Plan pays 100% after any applicable copay. For non-Network services, the Medical Plan pays 80% (of R&C) after you pay your calendar-year deductible and any applicable copay.

If you want to get a second surgical opinion (not required by the Medical Plan), the Medical Plan pays for second surgical opinions in the same manner as any doctor's office visit. You may visit a Network provider and get Network benefits, or a non-Network provider and receive non-Network benefits.

In addition to the services previously mentioned, the Medical Plan also covers the following services:

- Services of a physician for an office visit or house call for diagnosis and/or treatment of an injury, illness or disease, including pregnancy (a copay is required for visits to Network providers);
- Services of a certified nurse midwife within the scope of his/her certification referral by PCP is not required, provided at 100% of R&C;
- Professional private duty nursing services provided by a registered nurse, licensed practical nurse or licensed vocational nurse, other than a nurse who is a member of your immediate family or who lives with you. (If you use a non-Network provider, the benefits for a private duty nurse and/or visiting nurse are subject to a $10,000 annual limit);
- Services of a qualified physiotherapist (physical therapist) or a licensed speech therapist when prescribed by a PCP (Network) or an attending physician (Non Network) and the services are not educational in nature;
- Blood and blood derivatives, if not replaced or donated;
- Prostheses and their replacements when required due to the normal growth process of a child or when required as a result of a change in physical condition due to injury, illness or disease;
- Rental of hospital beds, wheelchairs and other durable medical or surgical equipment that is not generally of use to a person without an injury, illness or disease;
- Medical supplies that are not generally of use to a person without an injury, illness or disease;
- Ground ambulance services when determined by the Claims Administrator to be a Covered Health Service for adequate treatment of a medical emergency, to the first local hospital where treatment is provided. Ground ambulance service is also covered for transfers between hospitals and certain other health care institutions, provided you are so critically ill that the ground ambulance is necessary to your well being, the institution to which you are taken has some special facility for treatment of your particular condition that is not available to you otherwise, and that institution is the normal or usual place that other Plan participants living in the area would be taken for your particular specialized treatment;
- Air ambulance service used in lieu of ground ambulance service when such service is determined by the Claims Administrator to be a Covered Health Service appropriate for adequate treatment of a medical emergency;
- Initial pair of eyeglasses or contact lenses following eye surgery or injury;
- Treatment and office visit charges for the services of a chiropractor, podiatrist, obstetrician or gynecologist within the scope of his/her license subject to Plan limits;
- Medical services provided by a physician for treatment of accidental injury to natural teeth which occurs while covered by the Medical Plan; and
- Initial hearing aid(s) following ear surgery or injury.

OOA Option Benefits

Under the OOA option, you have certain Basic Benefits, most of which are not subject to a deductible. For benefits to which the deductible does apply, you must pay the deductible in any given calendar year before receiving benefits under the Medical Plan.

Covered Health Services eligible for Basic Benefits that exceed the basic medical coverage limits and certain non-basic benefit services or supplies are eligible for supplemental benefits. The Medical Plan generally pays 80% (of R&C) of charges for these covered expenses after you have met your deductible.

Out-Of-Pocket Maximum

After your covered out-of-pocket expenses reach the out-of-pocket maximum, the Medical Plan pays 100% (of R&C) of your covered expenses for the rest of the calendar year.

Basic Benefits

For care covered under Basic Benefits, you do not have to pay an annual deductible. Specific categories of Basic Benefits and the percentage of benefits that the Medical Plan pays are described as follows:

Preventive Care

Under the OOA option, preventive care benefits are covered at 100% of R&C without application of an annual deductible. Covered expenses include:

- Well child care;
- Immunizations; and
- Routine Health assessments
- Routine Mammograms

Inpatient Hospital Care

The Medical Plan pays 100% (of R&C) of your inpatient hospital Covered Health Service expenses for up to a maximum period of 120 days for each inpatient confinement after you pay the copay for each admission. The Medical Plan covers hospital room and board (up to the cost of a semi-private room), general nursing care and treatment in an intensive care or cardiac care unit.

If you have another hospital stay for the same or related condition and 90 days have passed since your last confinement or your hospital stay is for another condition, you receive a new 120-day maximum.

After you have reached the 120-day limit, hospital charges are eligible for payment under *Supplemental Benefits.*

Other hospital inpatient services are covered as Basic Benefits including:

- Special diets;
- Routine nursery care of the newborn during the mother's post-delivery confinement;

- Operating, delivery, recovery and treatment rooms and equipment;
- All recognized drugs and medicines for in-hospital use; dressings, ordinary splints and casts;
- X-ray exams, x-ray therapy, radiation therapy and treatment;
- Laboratory tests;
- Oxygen and oxygen therapy;
- Electrocardiograms and electroencephalograms;
- Physical therapy;
- Anesthesia;
- Processing and administering blood and blood derivatives if not replaced;
- Hemodialysis treatment;
- Chemotherapy;
- Electroshock therapy;
- Medical services for treatment of accidental injury which occurred while covered under the Medical Plan; or
- When a physician other than a dentist certifies that hospitalization is Medically Necessary to safeguard the life or health of the patient because of the existence of a specified non-Medical organic impairment, such as heart trouble or hemophilia; and

If the hospital has only private rooms, the Medical Plan pays 90% of the most prevalent private room rate in that hospital. Any excess charges are not eligible for supplemental benefits.

Outpatient Care

In many instances, you can avoid an overnight hospital stay by having a service or surgery performed as an outpatient at a hospital, stand-alone ambulatory surgical facility or doctor's office. The Medical Plan pays 100% (of R&C) of the covered charges for the following services for outpatient treatment:

- Surgery;
- Preadmission and diagnostic x-ray and laboratory tests including allergy testing;
- Hemodialysis treatment;
- Anesthesia;
- Chemotherapy,
- Radiation therapy;
- Electroshock therapy;
- Treatment in a hospital emergency room within 72 hours for a medical emergency after you pay a copay per emergency room visit per person if not admitted to the hospital as a result of the emergency room visit;
- Medical services for treatment of accidental injury which occurred while covered under the Medical Plan; or
- When a physician other than a dentist certifies that outpatient treatment is Medically Necessary to safeguard the life or health of the patient because of the existence of a specified non-Medical organic impairment, such as heart trouble or hemophilia.

Surgical Care

The Medical Plan pays 95% (of R&C) of your covered charges for surgical services. When surgery is performed in a hospital or an outpatient facility, the fees of an assistant surgeon also are covered at the same level if the services are Covered Health Services. The usual pre- and post-operative surgical care is included in determining the reasonable and customary charges. Charges for in-hospital physicians' visits are reimbursed at 90% of R&C.

Other Basic Medical Services

The Medical Plan also pays 100% (of R&C) of your covered charges for the following care:

- Second surgical opinions and a third opinion if two physicians do not agree on the need for the elective surgery;
- Diagnostic x-ray exams and lab tests including pap smears, x-rays performed by a chiropractor and. allergy testing (allergy treatment charges and office visits are covered as Supplemental benefits);
- Radiation and chemotherapy;
- Hospital-provided hemodialysis;
- Electroshock therapy;
- Well child immunizations, subject to certain limitations.

The Medical Plan pays 95% (of R&C) of your covered charges for the services of a certified nurse midwife within the scope of his/her certification.

- One in-hospital pediatric exam for a newborn during the mother's post delivery confinement;
- One in-hospital doctor visit per day;
- One in-hospital consultation between your doctor and a specialist while you are in the hospital;
- Administration of anesthesia by a certified registered nurse or a physician other than the operating or assistant surgeon.

Alternative Care

Alternative care is treatment in a facility other than a hospital such as a birthing center, hospice and skilled nursing facility or home health care.

The Medical Plan pays 100% (of R&C) of your covered charges for alternative care, subject to the Medical Plan's inpatient hospital guidelines

Supplemental Benefits

The Medical Plan pays 90% (of R&C) of your covered charges for emergency room physician charges if you receive treatment for a medical emergency within 72 hours of the emergency after you pay the emergency room visit copay.

After you have paid the calendar-year deductible, the Medical Plan pays 80% (of R&C) of the charges for the covered expenses listed below and 100% (of R&C) of any remaining charges for the covered expenses after your expenses reach the out-of-pocket maximum:

- Covered expenses eligible for Basic Benefits that exceed the basic medical coverage limits:
- Charges for semi-private hospital room and board and other services beyond 120 days;

- Services of a physician for an office visit or house call for diagnosis and/or treatment of an injury, illness or disease including pregnancy;
- Services of a physician, surgeon, anesthetist or certified nurse midwife that exceed those paid under Basic Benefits;
- Professional private duty nursing services provided by a registered nurse or a licensed practical nurse or a licensed vocational nurse other than a nurse who is a member of your immediate family or who lives with you;
- Services of a qualified physiotherapist (physical therapist) or a licensed speech therapist that are not educational in nature if prescribed by an attending physician;
- Blood and blood derivatives, if not replaced or donated;
- Prostheses and their replacements when required due to the normal growth process of a child or when required as a result of a change in physical condition due to injury, illness or disease;
- Rental of hospital beds, wheelchairs and other durable medical or surgical equipment that is not generally of use to a person without an injury, illness or disease;
- Medical supplies not generally of use to a person without an injury, illness or disease, to include ostomy supplies;
- Ground ambulance service, when determined by the Claims Administrator to be a Covered Health Service for adequate treatment of a medical emergency, to the first local hospital where treatment is provided. Ground ambulance service is also covered for transfers between hospitals and certain other health care institutions, provided you are so critically ill that the ground ambulance is a Covered Health Service necessary to your well being, the institution to which you are taken has some special facility for treatment of your particular condition that is not available to you otherwise, and that institution is the normal or usual place that other Plan participants living in that area would be taken for your particular specialized treatment;
- Air ambulance service used in lieu of ground ambulance service when determined by the Claims Administrator to be a Covered Health Service necessary for adequate treatment of a medical emergency;
- Initial pair of eyeglasses or contact lenses following eye surgery or injury;
- Treatment and office-visit charges for the services of a chiropractor or podiatrist acting within the scope of his/her license.
- Medical services provided by a physician for treatment of accidental injury to natural teeth which occurred while covered by the Medical Plan;
- Initial hearing aid(s) following ear surgery or injury; and
- Hospital emergency treatment not due to a medical emergency.

Deductible

No deductible applies to Basic Benefits. However, a deductible does apply to Supplemental Benefits. Your deductible is the initial amount paid toward, expenses for Covered Health Services each calendar year before you receive Supplemental benefits. Your deductible for a calendar year is $200; the two person deductible is $400; and the three person deductible is $600.

Other Deductible Notes:

- All family members may contribute toward the three or more person deductible. However, no person may contribute more than the individual amount.

- Any expenses incurred in the last three months of the year and applied to that year's deductible may be reused to meet the deductible in the next calendar year.
- Only one individual deductible will apply for benefits resulting from an accident involving two or more covered family members.
- Deductible amounts are subject to increase annually based on the percentage change in Medical Plan costs. Updates are published annually in the fourth quarter.
- Copays, out-of-pocket prescription expenses, behavioral health expenses, and non-covered charges do not count toward the OOA deductible.

Out of Pocket Maximum

After the calendar-year deductible is met, the Medical Plan generally pays 80% (of R&C) of the covered supplemental benefits. You pay the remaining 20%, up to the annual out-of-pocket maximum. This 20% is your coinsurance.

After your covered supplemental out-of-pocket expenses reach the OOA out-of-pocket maximum, the Medical Plan then pays 100% (of R&C) of your covered expenses for the balance of that calendar year. Only the OOA deductible and coinsurance apply toward the out-of-pocket maximum. Copays, out-of-pocket drug expenses, behavioral health expenses, and non-covered expenses do not count toward the OOA out-of-pocket maximum.

No one covered family member pays more than the individual out-of-pocket maximum. All covered family OOA deductibles and coinsurance are combined to determine when a family reaches the three or more person out-of pocket maximum. In some cases, families with four or more covered members may meet the three or more person out-of-pocket maximum even if all family members have not reached the individual out-of-pocket maximum.

Lifetime Maximum

The Medical Plan pays for covered benefit expenses up to an unlimited lifetime maximum for OOA care for active employees.

Organ and Tissue Transplant

Benefits for this program are described in the *Organ and Tissue Transplant* section of this SPD.

Exclusions and Limitations

The limitations and exclusions set forth below and throughout this document are not intended in any way to be exhaustive. The Medical Plan reserves the right to limit or exclude other services and supplies and the applicable charges that are determined to be inappropriate in the sound discretion of the Claim Administrator.

The Medical Plan does not cover certain types of expenses, including, but not limited to, the following:

- Custodial, domiciliary or sanitarium care, rest cures, or care in an institution that is primarily a place of rest, a home for the aged, a nursing or convalescent home, a skilled nursing home or any similar place except as specifically provided under the Plan;
- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan);
- Health services or other charges for any form of assisted reproductive technology, including donor compensation connected with the harvesting of donor eggs, or charges for procedures related to actual or attempted impregnation or fertilization or pregnancy of a surrogate mother other than health services or other charges relating to the pregnancy of a person covered under the Plan;
- Two days of hospital room and board for non-emergency Friday admission or one day of hospital room and board for non-emergency Saturday admission unless surgery is performed the day following admission;
- Charges for eye surgery when the primary purpose is to correct myopia, hyperopia or astigmatism, including, but not limited to, radial keratotomy and LASIK;
- Services or hospitalizations that begin before your effective date of coverage or after coverage has ended (except for hospital room and board charges as a hospital inpatient if you are already confined to a hospital when your coverage ends);
- Charges for services or supplies payable under Worker's Compensation or similar laws;
- Treatment resulting from a job-related accidental injury which is payable under company-sponsored disability plan;
- Smoking Cessation services, products or drugs
- Any procedure to restrict the intake of food or other nutritional material or to divert the passage of such material through the digestive tract, including but not limited to gastric bypass, gastric balloons, jejunal bypass, laparoscopic banding and stomach stapling.
- Services of Christian Science Practitioners
- Charges paid or payable under any government law or regulation;
- Services or supplies available from or covered by any governmental agency on plan;
- Charges for services or supplies provided in connection with any occupational injury, illness or disease arising out of and in the course of employment with any employer if the employer pays for such charges or you waive or fail to assert your rights with respect to such charges;
- Charges for any care, treatment, service or supplies other than those determined by the Claim Administrator to be a Covered Health Service for the treatment of injury, illness or disease other than preventive care as specified under the Plan;
- Treatment of an injury, illness or disease caused by service in the armed forces of any government or by an act of war, declared or undeclared, including armed aggression, riot or insurrection unless you are on company business, including travel, assignment and relocation outside of the United States;
- Charges for services or supplies needed as a result of an injury, illness or disease arising out of the participation in or attempt to commit a felony or assault;
- Charges for in-hospital personal services such as radio and TV rentals, guest meals or barber services;
- Services or supplies for which there is no legal obligation to pay or for which no charge will be made in the absence of Plan benefits;
- Charges for broken appointments;
- Charges for completion of forms, claim forms or filing of claims;
- Charges for over-the-counter medications and pharmaceutical purchases, whether prescribed by a physician or otherwise, except for insulin, diabetic supplies such as blood

testing aids and diagnostic urine tests, and hypodermic needles and syringes prescribed by a physician for use with covered injectables as set forth in the *Prescription Drug Program* section
- Any charges over the usual, reasonable and customary (R&C) fee;
- Charges in connection with any dental services, except as specifically provided under the Plan;
- Hearing aids or routine hearing exams except for the initial hearing aid(s) following ear surgery or injury and the exams for their prescription or fitting;
- Eyeglasses, contact lenses or exams for the prescription or their fitting except for the initially prescribed pair of eyeglasses or contact lenses after eye surgery or injury and the exams for the prescription or their fitting;
- Charges for physical therapy and speech therapy that are Educational in nature;
- Cosmetic surgery or treatment unless required to correct injury caused by an accident while you were covered under the Plan, or to correct birth defects or deformities, and charges for reconstructive surgery after other surgery covered under the Plan has been performed on the same part of the anatomy for treatment of an illness, injury or disease, shall not be excluded if they otherwise qualify as covered expenses;
- Any service or supply payable under the Cingular Medical Plus Plan.
- Charges for the evaluation of the suitability of an individual and/or his or her condition for any service, treatment or procedure excluded from coverage under the Plan;
- Charges for holistic medicine, services, supplies or treatment;
- Digestive aids, vitamins, minerals or other dietary supplements used solely as dietary supplements, regardless of whether such items are ordered or prescribed by a doctor;
- Services of Nutritionists or Dieticians
- Services or supplies for treatment of temporomandibular joint disorders or other conditions involving joints or muscles of the jaw by any method or procedure other than surgery;
- Hypnosis provided for any purpose;
- Acupuncture for any purpose except anesthesia;
- Aroma therapy, hypnotism, massage therapy, rolfing and other forms of alternative treatment as defined by the Office of alternative Medicine of the National Institutes of Health;
- Chiropractic care which is considered maintenance, preventive, palliative, passive or supportive in nature as determined by the Claim Administrator;
- Routine foot care;
- Cochlear implants;
- Charges for services or supplies incurred as a result of the failure to comply with Medicare utilization review requirements;
- Charges for services or supplies for a covered individual whose primary coverage is through a health maintenance organization (HMO) or other Network-based medical care program when the charges are excluded by the HMO or Network-based program due to non-compliance with that HMO's or program's guidelines;
- Charges for covered expenses under any provision of the Plan if already paid pursuant to any other provision of the Plan;
- Services or supplies provided other than those defined under the Plan;
- Experimental or Investigational Services and Unproven Services. The fact that an Experimental or Investigational Service or and Unproven Service is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental Investigational or Unproven in the treatment of that particular condition;
- Treatment of benign gynecomastia (abnormal breast enlargement in males);
- Medical and surgical treatment of excessive sweating (hyperhidrosis);

- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea;
- Appliances for snoring except when provided as a part of treatment for documented obstructive sleep apnea;
- Outpatient rehabilitation services or supplies for the treatment of a condition which ceases to be therapeutic and instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring;
- Chiropractic and osteopathic manipulative treatment to treat an illness;
- Speech therapy to treat stuttering, stammering or other articulation disorders;
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint except as a treatment of obstructive sleep apnea;
- Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. Replacement of an existing breast implant is considered a Reconstructive Procedure if the initial breast implant followed mastectomy;
- Physical conditioning programs equipment, or memberships including, athletic training, body-building exercise, fitness, or flexibility and diversion or general motivation;
- Wigs regardless of the reason for the hair loss;
- Enteral feedings and other nutritional and electrolyte supplements, infant formula, donor breast milk, nutritional or dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity, food of any kind, oral vitamins and oral minerals;
- Medical and surgical treatments to reverse a voluntary sterilization;
- Examinations, evaluations and reports not required for health reasons such as employment, school or insurance examinations;
- Orthotic appliance that straighten or reshape a body part; and
- Prescribed or non-prescribed medical supplies and disposable supplies such as elastic stockings, ace bandages, or gauze and dressings;
- Educational or developmental services;
- Any charges for services that are not Medically Necessary.

Schedule of Benefits

Covered Plan Service	**Point of Service (POS) Option** ***(UHC Choice Plus Network)***		**OOA Option**
	Network	**Non-Network**	
Annual Deductible	None	Individual: $430 2 Person: $860 3 or more: $1,290	Individual: $200 2 Person: $400 3 or more: $600
Out of Pocket Maximum	None	Individual: $2,430 2 Person: $3,860 3 or more: $5,290	Individual: $1,200 2 Person: $2,400 3 or more: $3,600
Inpatient Hospital Charges	100% after $35 Co-pay per admission	80% of R&C after deductible and after $35 Co-pay per admission	100% after $35 Co-pay per admission, for 120 days. Then 80% after deductible.
Surgeon, Asst. Surgeon	100%	80% of R&C after deductible	95% of R&C
Anesthetist,	100%	80% of R&C after	90% of R&C

Physicians Hospital Visits		deductible	(Certified Nurse Midwife-95% of R&C)
Outpatient Surgery	100%	80% of R&C after deductible	100% of R&C
Emergency room	100% after $100 copay per visit (waived if admitted)	80% of R&C after annual deductible and $100 copay per visit (waived if admitted)	100% of R&C after annual deductible and $100 co-pay per visit (waived if admitted)
Diagnostic Lab and X-Ray	100%	80% of R&C, after deductible	100% of R&C after deductible
Physician's Home or Office Visits	100% after $15 Co-pay per person	80% of R&C after deductible	80% of R&C after deductible
Physical Therapist	100%	80% of R&C after deductible	80% of R&C after deductible
Home Health Care (Pre-certification required, or no coverage)	100%, unlimited visits	80% of R&C up to 60 visits per year, $50 per visit maximum	100% of R&C unlimited visits
Hospice Care (Pre-certification required, or no coverage)	100%	$0	100% of R&C
Skilled Nursing Facility (Pre-certification required, or no coverage)	100% up to 100 day maximum Network and non Network	80% of R&C, after deductible, 60 day maximum Network and non Network	100% of R&C, 100 days annual maximum.
Birthing Center	100%	80% of R&C after deductible	100% of R&C
Other Services			
Ground or Air Ambulance	100%	80% of R&C after deductible	80% of R&C after deductible, $2,000 maximum for air ambulance
Blood/Plasma	100%	80% of R&C after deductible	80% of R&C after deductible
Prosthetics and rental of durable medical equipment	100%	80% of R&C after deductible	80% of R&C after deductible
Private Duty Nursing	100%	80% of R&C after deductible, $10,000 Annual limit	80% of R&C after deductible
Chiropractic or Podiatry Care	100% after $15 Co-pay per visit	80% of R&C after deductible	80% of R&C after deductible (Notification required after first visit)

Preventive Care	100% after $15 Co-pay per visit • Well Child Care • Immunizations • Routine Health Assessments • Routine Mammograms	$0	100% of R&C for: • Well Child Care • Immunizations • Routine Health Assessments • Routine Mammograms
Newborn Care	100% for each inpatient pediatric exam*	80% of R&C after deductible for 1 inpatient pediatric exam*	100% of R&C for 1 Inpatient Newborn Exam*
Obstetrical or Gynecological Care Ob $15 then global GYN AAO	100% after $15 Co-pay per visit Includes Depo-Provera Injections	80% of R&C after deductible, Includes Depo-Provera Injections	80 % of R&C after deductible Includes Depo-Provera Injections
**** Coordination of Benefits**	Non-duplication of payment; actual benefit amount offset by primary coverage payments	Non-duplication of payment; actual benefit amount offset by primary coverage payments	Non-duplication of payment; actual benefit amount offset by primary coverage payments
Behavioral Health	See "Behavioral Health Benefits"		

***Inpatient Pediatric exams beyond the first require that the newborn be enrolled as a Dependent within 31 days of birth.**

** The Coordination of Benefits (COB) provision in the Medical Plan pays only the difference between what it would have paid (if it were primary) and what the primary coverage does pay. For example, if your spouse's primary plan pays $80 and the Medical Plan would have paid $80 if it were primary, then the Medical Plan pays ZERO as secondary coverage. Another example: If your spouse's primary plan pays $80 and the Medical Plan would have paid $90 if it were primary, then the Medical Plan pays $10 as secondary coverage.

Prescription Drug Benefits

You and your eligible Dependents are automatically enrolled in the Prescription Drug Plan when you enroll in the POS, EPO, or OOA options. Both retail and mail order programs are available. The Prescription Drug Program is administered by Caremark. See *Contact Information*. You may purchase covered prescriptions or supplies (up to a 30-day supply) at a participating retail network pharmacy using your drug card. For maintenance prescriptions or supplies – those requiring more than a 30-day supply – the mail order prescription program provides up to a 90-day supply per order. Prescriptions and supplies purchased through the participating pharmacy retail network are subject to coinsurance. No claim forms are required. Prescriptions and supplies may also be purchased from non-participating pharmacies. Such purchases require full payment and submission of a claim form for reimbursement.

What is Covered

Covered prescription drugs include FDA approved medicine required by federal law to be dispensed only with a doctor's prescription and are dispensed subject to the professional judgment of the dispensing pharmacist, limitations imposed on controlled substances, and the manufacturer's recommendations.

Prescriptions for anorexiant medications, used in the treatment of obesity, require participation in the Claim Administrator's, AdvancedCare Program for weight management and must be pre-certified into the program before prescriptions are dispensed. Contact the Prescription Drug Claims Administrator for details.

Only the following over-the-counter (OTC) drugs and supplies are covered under the generic, formulary and brand tiers.

- Injectible insulin:
- Diabetic supplies such as blood testing aids and diagnostic urine tests; and
- Hypodermic needles and syringes for use with covered injectibles if prescribed by a doctor.

Personal Choice Drugs

The following list includes but is not limited to the classes of drugs or drugs to treat certain conditions, as well as certain devices and supplies that are available at the plan's discounted prices at 100% coinsurance:

- Contraceptive Devices
- Contraceptive Injectibles
- Diet/Weight Loss Medications (except when participating in the Advanced Care Program for weight management described above)
- Erective Dysfunction
- Fertility Drugs
- Hair Loss Drugs (e.g., Propecia)
- Influenza Drugs
- Nail Fungus Drugs
- Nutritional and Diet Supplements
- Ostomy Supplies
- Respiratory Therapy and other Prescription Devices
- Smoking Cessation products, including but not limited to:
    - Nicotrol Inhaler and Nasal Spray
    - Zyban
    - Habitrol
- Toxoids
- Vaccines
- Wrinkle-treatment drugs (e.g., Renovia)

Purchasing Brand Name Drugs When a Generic is Available

Generics are determined by the Food and Drug Administration to be chemically and therapeutically identical to their brand name counterpart and are almost always less expensive than the brand drug. When a prescription is filled with a formulary or non-formulary brand drug and a generic is available, you will be charged the coinsurance on the generic drug price plus the price difference between the two drugs or, if greater, the coinsurance amount on the brand

drug. This additional cost does not apply toward the out-of pocket limit. In certain situations, where there are multiple generic options the additional cost penalty may be determined by the prescription drug Claims Administrator at their discretion.

Out-of-Pocket Limit

Your annual out of pocket cost for co-insurance is limited to $1,000 per person and $2,000 per family. Out of pocket costs for the purchase of personal choice drugs and the price difference for the purchase of a brand drug when a generic is available do not apply toward this out of pocket limitation.

The following require a diagnosis before dispensing:

- Retin A, if for a participant age 26 or over
- Smoking Cessation Products

Retail Prescription Purchase Program

Members receive a Caremark Prescription Drug identification card (two cards per covered member) for prescription drug purchases under the Retail Prescription Drug Program.

For retail prescription drugs, your benefits are paid based on whether or not your prescription is filled at a participating pharmacy. If your prescription is filled at a participating pharmacy, then you pay only the applicable coinsurance amount. There is no limit on the number of refills, except as limited by your doctor's original prescription and applicable state or federal laws. No claim forms are required when you use your prescription drug identification card. The amount of coinsurance depends on whether the prescription is for a generic, formulary brand name or non-formulary brand name drug. Formulary brand name drugs are those for which the prescription drug claims administrator has negotiated discounts.

If you use a non-participating pharmacy, or if you do not present your prescription drug identification card at a participating pharmacy, you will be required to pay full price for the prescription and submit a claim form in order to be reimbursed. Reimbursements will be 50% of the price of the drug. Claim forms must be submitted for reimbursement to the prescription drug program Claims Administrator.

Prescriptions filled at retail pharmacies are generally limited to a 30-day supply. Certain prescriptions are routinely dispensed at retail for up to a 90-day regimen – these may be purchased at retail but the up to 90-day mail order coinsurance amounts will apply).

Mail Order Prescription Purchase Program

If you receive a prescription for a medication requiring long term use, you may use the mail order program. Instead of filling a prescription at a retail pharmacy, you may order up to a 90-day supply of prescription drugs through the mail order prescription drug administrator. You may ask your physician for two prescriptions. The first, for a 30-day supply, can be filled using your drug card at a participating pharmacy. The second, for up to a 90-day supply, can then be filled through the mail order program.

The mail order program can reduce your out-of-pocket expenses for prescription drugs that are used over an extended period. To use the program: Complete the patient profile questionnaire with your first order. Complete the order envelope. Enclose the written prescription and the applicable coinsurance payment for each prescription. You may determine, in advance of ordering, the cost of a prescription and your coinsurance cost by contacting Caremark, the prescription drug plan administrator at **1-800-388-2085 or on the internet at www.caremark.com**

A maximum of up to a 90-day supply of covered drugs and medicines per prescription or refill will be dispensed by the mail order drug program administrator, subject to the, professional judgment of the dispensing pharmacist, limitations imposed on controlled substances, and the manufacturer's recommendations.

Prescriptions will not be filled or refilled in the following instances:
- For all covered drugs except controlled substances, more than 12 months after issuance;
- For controlled substances, more than six (6) months after issuance; or
- If prohibited by applicable law or regulation.

Your prescription will be reviewed by a pharmacist, checked against your patient profile and dispensed and verified by the administrator's quality control department. Your order will normally be shipped to you via U.S. mail to arrive within 14 days of the day you mailed your prescription.

The following drugs cannot be purchased through the mail service program:
- Drugs that require constant refrigeration during shipment;
- Drugs that cannot be shipped due to size, weight, fragility or other factors, and
- Drugs unsuitable for self-administration, including, but not limited to, diagnostic agents.

Questions concerning both the Retail and Mail Order Prescription Drug programs may be directed to the Prescription Drug Claims Administrator. They will answer your questions about:
- Refilling an existing mail order prescription;
- Covered drugs;
- Status of a mail order request;
- Identifying a participating pharmacy in your area; and
- Obtaining mail order envelopes and claim forms.

Schedule of Benefits

Prescription Program	Employee Pays Coinsurance (*% of the price of the drug)	Minimum per Rx or refill	Maximum per Rx or refill
Retail (up to a 30 day supply per Rx or refill)			
Generic	15%	$10	$25
Formulary	20%	$20	$60
Brand	30%	$30	$80
Personal Choice	100%	N/A	N/A
Mail Order (up to a 90 day supply per Rx or refill)			

Generic	15%	$15	$50
Formulary	20%	$30	$70
Brand	30%	$45	$90
Personal Choice	100%	N/A	N/A

Brand Restriction: If a generic drug is available and a brand drug is purchased, you will pay the greater of (a) the generic coinsurance amount plus the price difference between the brand and the generic or (b) the brand coinsurance amount.

Maximum Annual Out-of- Pocket (OOP) Costs: $1,000 per person; $2,000 per family (Personal Choice purchases and Brand restriction penalties do not accrue to the max OOP.)

*If you purchase prescription drugs at a non-participating pharmacy or fail to use your prescription drug card at a participating pharmacy, you will pay the full price and file a claim for reimbursement. The discount for Personal Choice drugs is not available at non-participating pharmacies. See specifics above.

Behavioral Health Benefit

Applicable to the POS, OOA, and EPO Plan Options

Behavioral health benefits are provided through a Network of behavioral health counselors, doctors and facilities. These providers are managed through a national Behavioral Health Claims Administrator. You receive maximum benefits for behavioral health care when you use a participating provider and are pre-certified for certain types of care.

***To receive any benefits, you must pre-certify, before admission, any mental health or chemical dependency inpatient care by calling the Behavioral Health Claims Administrator, United Behavioral Health at* 1-800-538-8101.** In the case of an emergency admission, you must call the Behavioral Health Claims Administrator within 24 hours of the admission. When you pre-certify your hospital stay, the Behavioral Health Claims Administrator will refer you to one of its participating providers. You receive maximum benefits when you use participating providers.

When you use a participating provider or facility, you will not need to file a claim form with the Behavioral Health Claims Administrator.

Inpatient or Outpatient Care

Benefits for behavioral health care also vary depending on whether you or a covered Dependent are receiving care as a hospital inpatient or as an outpatient. Outpatient care can take place at a clinic or doctor's office.

You can receive benefits for covered expenses for clinically indicated treatment of mental health and chemical dependency care. "Clinically indicated" means care that meets all the following criteria:

- Adequate and essential therapeutic response provided for evaluation or treatment consistent with the symptoms;

- Proper diagnosis and treatment appropriate for the individual's illness;
- Disease or condition as defined by standard diagnostic nomenclatures (DSM-1V or its equivalent in ICD-9-CM);
- Reasonably expected to improve an individual's illness, condition or level of functioning;
- Safe and effective according to nationally accepted standard clinical evidence generally recognized by mental health or chemical dependency care professionals or publications; and
- Appropriate and cost-effective level of care that can safely be provided for the individual's diagnosed condition in accordance with professional and technical standards.

Alternative to Behavioral Health Inpatient Care: When pre-certifying for inpatient care, the Behavioral Health Claims Administrator may suggest alternative treatment options instead of inpatient care.

Psychological Testing Benefit – Benefits for psychological testing are paid at the same rate as outpatient Mental Health Benefits with the $15 copay applied per hour. All psychological testing must be pre-certified by calling the Behavioral Health Claims Administrator, regardless of the provider you use. Only the number of hours pre-certified by the Behavioral Health Claims Administrator is paid.

Approved Providers You'll want to verify that your provider's credentials meet the Behavioral Health Claims Administrator's requirements for reimbursement. Approved providers include:
- Licensed Professional Counselor;
- Licensed Marriage, Family and Child Counselor;
- Licensed Doctoral-level Psychologist (Ph.D., Ed.D., Psy.D.);
- Licensed Psychiatric Nurse with a Master of Science in Nursing and an RN license;
- Licensed Master's prepared Social Worker (some states may have additional requirements or may certify rather than license these professionals); and
- Licensed Marriage and Family Therapist (LMFT).

Schedule of Behavioral Health Benefits

Behavioral Health Benefits

You may obtain, without charge, a listing of the Network Behavioral Health providers by contacting the Behavioral Health Claims Administrator.

Benefits	Network	Non-Network
Behavioral Health Benefits		
Inpatient:	• Pays 100% after $35 Co-pay per admission	• 50% of R&C up to $300 per day
Psychological Testing	• 100% after a $15 copay per hour	• 100% after a $15 copay per hour

Benefits	Network	Non-Network
Outpatient:	• 100% MD visits • 80% for all other network Mental Health providers	• MD visits – 50% of R&C. to $50 per visit if pre-certified. • Other network Mental Health providers – 80% of billed Charges to $60 maximum per visit
Certification Requirements:	• All non-emergency services must be precertified prior to receipt of care. • All emergency services must be certified within 24 hours of receipt of care	• All non-emergency services must be precertified prior to receipt of care. • All emergency services must be certified within 24 hours of receipt of care
Deductibles	• None	• None
Annual Maximums	• Outpatient ▪ 20 visit annual maximum for Non-MD • Inpatient ▪ None, MH or CD	• Outpatient ▪ 20 visit annual maximum for all provider types • Inpatient • 20-day annual maximum, MH & CD combined
Lifetime Maximums	• None	• None
Out-of-pocket Maximum	• None	• None

Notes:

- In the event of an emergency admission, the behavioral health claims administrator must be notified within 24 hours and continued confinement certified for coverage to apply.
- Out-of-pocket mental health and chemical dependency expenses do not count toward the medical deductible or out-of-pocket maximum for other types of expenses.

Additional Exclusions and Limitations

Certain behavioral health expenses are not covered, including, but not limited to, the following:

- Academic education during residential treatment;
- Administrative psychiatric services when these are the only services rendered (for example, expert testimony and medical records review and maintenance);
- Aversive treatment;
- BEAM (Brain Electrical Activity Mapping);
- Bioenergetic therapy;
- Carbon dioxide therapy;
- Chemical dependency treatment involving nutritionally-based therapies, non-abstinence-based treatment or aversion therapy, or individual therapy without a structured outpatient treatment program unless the Behavioral Health Claims Administrator determines that such services are appropriate for the treatment of a DSM-W Mental Disorder or its equivalent in ICD-9CM;
- Confrontation therapy;

- Consultation with a mental health professional for adjudication of marital, Child support and custody court cases;
- Court-ordered psychiatric or substance abuse treatment unless the Behavioral Health Claims Administrator determines that such service is appropriate for the treatment of a DSM-TV Mental Disorder or its equivalent in 1CD-9CM;
- Crystal healing treatment;
- Cult deprogramming;
- Eating disorder and gambling programs based solely on the 12-Step Model;
- Educational evaluation and therapy;
- Environmental ecology treatments;
- EST (Erhard Seminar Training) or similar motivational services;
- Evaluations, consultations, testing or therapy for educational, professional training, or for investigation purposes relating to employment insurance, judicial or administrative proceedings;
- Experimental or investigation therapies;
- Expressive therapies (for example, art, poetry, movement and psychodrama) as separately billed services;
- EMDR (Eye Movement Desensitization and Reprocessing);
- Guided imagery;
- Hemodialysis for schizophrenia;
- Hyperbaric or normobaric oxygen therapy;
- L-tryptophan and vitamins, except thiamine injections on admission for alcoholism, when there is a diagnosed nutritional deficiency;
- Marathon therapy;
- Marriage counseling except when rendered in connection with a DSM-1V Mental Disorder or its equivalent in ICD-9CM;
- Megavitamin therapy;
- Narcotherapy with LSD;
- Non-abstinence based or nutritionally based chemical dependency treatment;
- Orthomolecular therapy;
- Prescription drugs except when dispensed by a hospital, residential treatment center or day treatment program to a covered individual who, at the time of dispensing, is receiving treatment at the appropriate facility or program;
- Primal therapy;
- Rolfing;
- Sedative action electrostimulation therapy;
- Sex therapy (without a DSM-lV diagnosis or its equivalent in ICD-9CM);
- Supervision of treatment team;
- Transcendental meditation;
- Treatment for personal or professional growth, development, treating or professional certification;
- Treatment or consultation provided via telephone unless the Behavioral Health Claims Administrator determines that such services are Medically Necessary for the treatment of a DSM-IV Mental Disorder of its equivalent in ICD-9CM;
- Treatments or testing for mental retardation, autism, pervasive developmental disorders, chronic organic brain syndrome, learning disability or transsexualism unless the Behavioral Health Claims Administrator determines that such services are Medically Necessary for the treatment of a DSM-lV Mental Disorder or its equivalent in ICD-9CM; and

- Z-therapy, also known as "holding therapy".

Benefits – SNET Retiree Medical Plan

The following section is applicable only to eligible employees covered by the applicable labor agreements between Cingular Wireless and the CWA covering CWA District 1 (formerly SNET) who retire on or before December 13, 2005 and who meet all other eligibility requirements to receive retiree medical and dental coverage ("SNET Retirees"). The **Eligibility, Enrollment and Other Administrative Provisions** section of the SPD contains additional rules regarding the SNET Retirees and their eligibility for these benefits. That section governs eligibility for these benefits and must be consulted.

Overview

The Company offers the following types of healthcare options:

- Point of Service ("POS") option
- An Out Of Area ("OOA") option.
- Managed Care Alternatives to plan Coverage
  - Exclusive Provider Organization ("EPO") option

The POS and EPO options are available in certain geographic areas. If you live in a zip code area serviced by a POS and/or EPO, you can enroll in only one of these options. The OOA is available only for Employees or Retirees who do not live in an area serviced by the POS option. Employees who enroll in the POS, EPO or OOA option are automatically enrolled in the Prescription Drug component of this Medical Plan. Employees who enroll in the POS or OOA option are automatically enrolled in the Behavioral Health component of this Medical Plan.

If you elect coverage with an EPO option, as an alternative to coverage under the Plan, you are subject to the benefits, terms and limitations of that option, including that option's claims appeal process. For more information about these options, contact them for a copy of their insurance certificate/booklet or SPD. These options are not described in this booklet.

The Medical Plan provides different levels of benefits depending on whether or not you live within a Network area. You are automatically eligible for Network benefits if you live within a Medical Plan Network area based on your home address zip code.

You receive Network benefits through the POS option when you coordinate your care through a Primary Care Physician ("PCP") whom you select. If you choose not to use a PCP, you are eligible for non-Network benefits.

If you live outside a POS Network area, you are eligible for the OOA option. However, you and your Dependents may elect at any time to enroll in the POS option. If you elect to enroll in the POS, you can elect to return to the OOA option only during a subsequent annual enrollment period. Please contact the **Cingular Wireless Benefits Service Center** for more information.

The Claims Administrator is responsible for management of the POS Network and for the determination of Network, Non-Network and OOA option benefits (other than benefits available under the programs for behavioral health care and prescription drugs). Regardless of whether you live in or outside a POS Network area, the Medical Plan also provides benefits for behavioral health care and prescription drugs.

Many types of providers are covered by the behavioral health care program. Maximum benefits are received when you use the program's participating providers. Benefits may also vary depending on whether care is provided as an inpatient or as an outpatient. See the *Behavioral Health Care* section for more information.

You may purchase prescription drugs using a prescription card at a participating pharmacy or have them delivered to your home through the mail order program. See the *Prescription Drugs Section* for more information about the retail and mail order programs.

Coverage is not automatic. To have coverage under the Medical Plan, you must enroll.

Plan Details

The SNET Retiree Medical Plan POS Option, covers preventive health care – routine physicals, gynecological exam well-baby care, and immunizations – and encourages early diagnosis of medical problems.

The POS Option features a Network of physicians, hospitals, and other medical care providers. Under the POS Option, you'll need to select a primary care physician ("PCP") to coordinate all your care. However, each time you need medical care, you can use any physician or hospital of your choice, but the level of benefits you receive will be different, depending on whether you use network or non-network providers, or are eligible for OOA coverage:

Network and Non-Network Areas

Network

If you receive care from Network providers, you must work directly with a primary care physician (PCP) for all of your health care needs. You'll have the opportunity to choose a PCP from a Network directory that will be available to you during enrollment.

If you need to see a specialist, your PCP must arrange this for you through a prior written referral. If you don't see your PCP first and receive a written referral, you will receive non-network coverage.

If you use any medical facilities and providers without the involvement of a PCP, you will pay more for these services. You can designate any doctor in the Network as your PCP and go to any hospital in the Network. There is no mileage restriction for how far you can travel.

If you're not eligible for the POS Network, based on your home address, but your work location is in a Network service area, you can use network providers in that area. You'll need to indicate during annual enrollment that you're participating in the POS Network based on your work location.

If you choose to receive care from non-network providers under these circumstances, you will receive the non-network – not OOA – level of benefits.

Providers who are members of the POS option network have agreed to provide services at negotiated rates. For this reason, if you use network providers, you'll typically save on out-of-pocket expenses. That's because you are not required to pay deductibles or coinsurance for services performed by or referred by your PCP.

To ensure that you receive the highest level of benefits, all of your Network care must be coordinated through your PCP. Your PCP is someone you need to consult with for all your health care needs. There may be times when your PCP feels it is Medically Necessary to refer you to a specialist or recommend other types of care. In these cases, your PCP will be responsible for arranging this care for you through a prior written referral to an network specialist, or by arranging other services, such as hospitalization. In some instances, your PCP may refer you to a provider outside the network if it's clinically indicated (for example, if you have a rare illness and the Claims Administrator does not have a provider in their Network who specializes in that illness). Some other important advantages to receiving care from and/or being referred to network providers are:

- Coverage for preventive care and wellness services
- No claim forms to fill out – network providers handle this for you;
- No guesswork on what's covered and what isn't, or whether or not the charges are within reasonable and customary (R&C) guidelines. Your PCP handles these matters up front with the Claims Administrator; and
- No requirements for pre-certification of medical services such as hospitalization, physical therapy, private duty nursing, and chiropractic treatment. Your PCP handles all of this for you.

Important Note: If you receive care from a provider in the network before checking with your PCP, you will receive the non-network level of benefits and pay more for services. You must always contact your PCP before receiving any non-emergency medical services. Keep in mind, if you choose to use network providers without getting a written referral from your PCP, you will need to receive pre-certification for some services.

The Role of the PCP

Each member of your family covered under the POS Option can choose their own PCP from the *SNET Retiree POS Option Provider Directory*. The PCP you select is responsible for coordinating all of your medical care and, when clinically indicated, providing you with a *written referral* for specialty and hospital care. Should you wish to change your PCP at any time after making your selection, you may call The Claims Administrator at 1-866-501-3068

It's important to contact your PCP whenever you have questions about your health. Your PCP is responsible for coordinating the care for your total medical needs. He or she will personally attend to you, as well as oversee and provide *written referrals to specialists for all your non-emergency Network care*. Working with your PCP helps to manage your care on an individual basis, which ensures that you're not receiving unnecessary treatment, tests, or unhealthy combinations of medications. You can also eliminate the need to file claim forms for the services you receive by your PCP, or for care he or she refers, and can be assured that you pay only the appropriate copayment for these network benefits.

Consult your PCP when you think you need a referral, and he or she will decide if an office visit is necessary, or whether a referral can be issued via the mail or fax to a participating specialist.

For women, a referral is not required for an annual routine visit to a gynecologist (and follow-up) or a visit for pregnancy. Referrals are valid for 90 days, as long as you remain a member of the POS Option. Once you have seen a specialist, any recommendation for additional treatments or tests must be approved by your PCP.

There are several benefits available to you when you select a PCP who participates in the POS Option. The primary one is that your PCP, being responsible for coordinating your medical care, will have total knowledge of the services you receive. Seeking advice from your PCP can also save you time and effort in locating a specialist to ensure that you receive appropriate treatment.

Non-Network

At any time, you can choose to go to a non-network provider, or to a network provider without getting a written referral from your PCP. Generally when you choose to receive care under these circumstances, you'll pay more. This is because your care will be subject to an annual deductible and coinsurance, which generally results in higher out-of-pocket expenses for you. You may also pay more because providers who don't participate in the network have not negotiated the lower rates available from network participants. If you receive care from non-network providers, or go to a network provider without receiving a written referral from your PCP, you will be responsible for obtaining pre-certification for certain services such as hospitalization, physical therapy, private duty nursing, and chiropractic services. If you forget to have non-network services precertified and it's later determined the services were not Covered Health Services, your benefits may be reduced or denied.

OOA Coverage

Most SNET retirees live in the POS network service area. If your home address is outside the network area, you will be designated as eligible for OOA coverage. With OOA coverage, you can choose to receive care from any provider. You will pay deductibles and coinsurance for the services you receive. If you prefer, you can use network providers closer to your work location. You must indicate your intention to do this at enrollment. If you elect to receive care from a network physician and then visit a physician who is not in the network, you will receive payment at the non-network level – not the OOA coverage level.

Emergency Care

There are certain procedures you must follow in the event of an emergency.

Within The Network Service area

Call your PCP first for help. Participating PCPs are required to provide emergency coverage 24 hours a day, seven days a week, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency treatment. If you seek emergency room treatment:

- Have the emergency room contact your PCP immediately. Your PCP knows you and your medical history and is responsible for coordinating your care.
- Call the Claims Administrator within 24 hours to report the emergency.

- Do not request a referral from your PCP for emergency services after you have received treatment. The Claims Administrator will make the coverage determination by reviewing your emergency room medical record. Services which do not qualify as an emergency will be subject to the annual deductible and coinsurance.

Outside The Network Service area

Seek the nearest emergency treatment for any illness or injury that would be considered an emergency. Call your PCP and the Claims Administrator within 24 hours of receiving any emergency care. Any follow-up care that you require while outside of the service area must be requested by your PCP and approved by the Claims Administrator for you to obtain full coverage. Otherwise, you will be subject to the annual deductible and coinsurance.

Follow-Up Care After All Emergencies

All follow-up care after emergency treatment will only receive full coverage with a prior written referral from your PCP, both within and outside of your Claims Administrators service area. Examples of follow-up care include suture removal, cast removal, X-rays, and clinic and emergency room revisits. If you do not obtain a prior written referral for follow-up care, you will be subject to the annual deductible and coinsurance.

Guidelines for Emergency Care

To avoid problems, it is essential that you understand your coverage for emergency care. Medically Necessary emergency care is covered, no matter where, no matter when. However, chronic or less severe problems should be handled during routine office hours. A $50 copayment applies for emergency room usage. This copayment is waived if you are admitted; the hospital copayment would apply. (Please see examples below of what is and what is not considered an emergency.)

Non-emergency treatment obtained in hospital emergency rooms will be subject to the annual deductible and coinsurance.

To qualify as an emergency, the following four requirements indicating a life-threatening circumstance must be met:

- The symptoms must be severe
- The symptoms must occur suddenly. Cases in which symptoms have existed over a period of time without the person seeking medical attention will not be covered as emergencies.
- Immediate medical attention must be sought. If there is a significant time lapse between the onset of symptoms or an injury and the time you seek medical treatment, the claim will not be considered an emergency.
- Immediate care must be Medically Necessary.

Conditions Suggesting the Need for Emergency Care	**Conditions Suggesting the Need for Urgent or Routine Care**
To qualify for Network coverage, emergency care must be provided to treat a sudden, serious medical condition that requires immediate medical care, without which your life	*For treatment of urgent or routine medical conditions, you should first contact your primary care*

may be in danger, or may lead to serious medical consequences without immediate care, such as:

- an apparent heart attack, including chest pain extending to the arms and jaw
- shortness of breath or difficulty breathing
- excessive bleeding
- loss of consciousness
- convulsions
- symptoms of a stroke, including sudden paralysis and/or slurred speech, lack of responsiveness, severe headache
- severe or multiple injuries, including fractures
- allergic reactions
- apparent poisoning

physician. Examples of urgent care conditions include:

- sprains, strains
- fevers
- bad cuts
- skin rashes
- excessive vomiting
- stomach pain or cramps
- prolonged diarrhea
- bad colds, sore throats, coughs
- minor burns
- swollen glands.

Benefits Summary

Network Benefits

If you use Network providers that are referred by your PCP, you pay an office visit fee or copayment for covered services, which currently are:

- $0 for laboratory services.
- $0 for gynecological well care (an exam by an obstetrician or gynecologist), including annual exams, Pap smears, and mammograms, based on American Medical Association (AMA) guidelines.
- $10 for an office visit to a PCP. PCPs include:
  - Pediatricians;
  - Internists; and
  - Family and general practitioners.
- $20 for an office visit to a specialist (any doctor other than those categories listed as PCPs) upon obtaining a written referral from your PCP.
- $125 per hospital admission with a maximum of three copayments per calendar year.
- $50 copayment for outpatient surgery (includes surgeon, anesthesiologist, laboratory, and facility charges).
- $10 per visit to a PCP for adult preventive health, including physical exams, based on AMA guidelines.
- $0 for pediatric preventive health services through age 17, based on AMA guidelines.
- $0 for radiology services.
- $50 for emergency room ($50 copayment is waived if you are admitted to the hospital; if admitted, the $250 hospital admission copayment applies).
- Network copayments do not apply toward Non-Network deductibles or out-of-pocket maximums.

Non-Network and OOA Benefits

Deductibles

You and your Dependents pay a certain amount of covered expenses each year for Non-Network and OOA services before the POS Option begins to pay benefits. The amount you pay is called the *annual deductible*. The following expenses cannot be used to satisfy the deductible:

- Copays
- Out-of-pocket drug expenses
- Penalties
- Behavioral health expenses; and,
- Non-covered charges

Currently, your deductible depends on whether you receive non-network care or have OOA coverage.

Annual Deductible			
	Network	**Non-Network**	**OOA**
Individual	**None**	**$ 300 per calendar year**	**$ 250 per calendar year**
Two Person	**None**	**$ 600 per calendar year**	**$ 500 per calendar year**
Family (3 or more)	**None**	**$ 900 per calendar year**	**$ 750 per calendar year**

How You Meet the Deductible

You can meet the annual deductible with non-network or OOA coverage expenses as follows:

Individual coverage: If you have coverage for yourself only, you pay expenses up to the individual deductible amount before the POS Option begins to pay benefits.

Two-person coverage:
If you have coverage for yourself and one Dependent, each individual must meet the individual deductible before the POS Option begins to pay benefits for that individual.

Family coverage: If you have coverage for yourself and two or more Dependents, your deductible can be satisfied in one of two ways before the POS Option begins to pay benefits:

- You can pay covered expenses for one family member (you or a Dependent) up to the individual deductible; then, the covered expenses of the remaining family members are combined to satisfy the remainder of the family deductible; or

- The family deductible can be satisfied when covered expenses for all family members reach the family deductible (even if this happens before one family member reaches the individual deductible).

Coinsurance Maximums

One important feature when using Non-Network or OOA providers is the coinsurance maximum. The maximum protects you when you have very high medical expenses by limiting the amount you will pay for covered medical expenses for the year.

When your share of expenses during the year reaches the coinsurance maximum, the POS Option pays 100% of R&C charges for most covered expenses for the rest of the year.

In general, your share of expenses includes your co-insurance percentage of R&C charges, after the deductible.

Expenses which do not apply to the coinsurance maximum include:

- your deductible,
- amounts above reasonable and customary charges,
- Network copayments,
- prescription drug copayments,
- mental health and chemical dependence out of pocket charges, and ;
- expenses for services that are not Covered Health Services. (You must continue to pay these expenses even after you reach your coinsurance maximum.)

Annual Co-insurance Maximum		
	Non-Network	**OOA**
Individual	$2,000	$1,000
Two Person	$4,000	$2,000
Family	$6,000	$3,000

Lifetime Maximum

The Medical Plan pays for covered benefit expenses up to a lifetime maximum of $1,000,000.

Precertification Guidelines

The Claims Administrator's pre-certification guidelines help ensure that the medical care recommended for you is appropriate and that you will receive full benefits. If you are using non-network or OOA providers, you must call the Claims Administrator before you are admitted to a hospital or receive certain medical services. You also must call the Claims Administrator if you are using an network provider without getting a written referral from your PCP.

How Pre-certification Works

Pre-certification is important because getting prior approval is designed to:

- Help you receive maximum benefits.

- Help you avoid unnecessary time and treatment in the hospital.
- Educate you about the types of treatment available to you under the POS Option.
- Offer treatment alternatives for your situation.
- Monitor your progress during ongoing treatment.
- Determine whether a service is a Covered Health Service and covered by the POS Option.

You must call the Claims Administrator if you're using non-network or OOA coverage providers to be sure you receive the maximum benefits. You also must call if you use network providers who are not referred in writing by your PCP, or whenever you or a Dependent needs to be hospitalized, or if you need certain medical services. If you do not contact the Claims Administrator to pre-certify medical services, your benefits may be reduced to 50% or, if the Claims Administrator determines that the treatment is not a Covered Health Service, benefits will be denied.

Services requiring Precertification are: Home Health Care, Inpatient Hospital Confinement, Infertility, Private Duty Nurse, Skilled Nursing Facility, Surgery (inpatient and outpatient), Cardiac Rehabilitation and Durable Medical Equipment.

In critical emergency situations, you should seek emergency medical assistance immediately. Depending on the type of admission, you or a representative must notify the Claims Administrator (or United Behavioral Health in the case of a behavioral health admission) within 24 hours of an emergency hospital admission.

Physical Therapy and Chiropractic Treatment Planning

Treatment planning helps you manage recurring physical therapy or chiropractic services and ensures that you receive the most appropriate treatment for your situation without unnecessary repetition of services.

If a Treatment Plan is not submitted immediately after your initial visit or the Treatment Plan is incomplete, you and your provider will be informed that any subsequent claims will not be processed until a complete Treatment Plan is received and approved. If a Treatment Plan is not submitted, your claim will not be paid. Keep in mind that it is your responsibility to ensure that your provider submits a Treatment Plan.

Covered Expenses – POS and OOA Options

In this section, you will find information about the medical services covered under the POS and OOA options. Services are listed in alphabetical order to make it easy for you to find the information you need.

What's Covered

The POS and OOA options cover treatments and services which meet the definition of Covered Health Services and certain supplies. Certain services are subject to pre-certification. It is important to note that just because a physician orders a specific treatment or service does not mean it will be covered if it is determined to be either not covered under the POS and OOA options or is not a Covered Health Service based on review by the Claims Administrator.

The amount the SNET Medical Plan pays differs based on whether your care is provided by or referred in writing by your PCP, or you choose to bypass the PCP and access care without a referral or if you are covered by the OOA option.

- If your care is performed by or referred in writing by your PCP, the POS option pays 100% of a negotiated fee after you make any required copayment.
- If your care is not provided by or referred in writing by your PCP, you pay 100% until you reach the deductible, then the POS option generally pays 70% of R&C charges after you meet the deductible. You pay the additional 30%, which is applied to your annual coinsurance maximum.
- If you have OOA coverage, you pay 100% until you reach the deductible, then the Medical Plan generally pays 80% of R&C charges after you meet the deductible. You pay the additional 20%, which is applied to your annual coinsurance maximum.

These coinsurance percentages apply to all the following covered services unless otherwise indicated. The following information summarizes and outlines how the Medical Plan pays benefits for covered services.

- **Allergy Testing and Treatment**
- **Anesthetics**: if administered in a hospital for the Non-Network and OOA options
- **Blood**: Autologous transfer and blood storage are not covered.
- **Cardiac Rehabilitation**: The deductible applies.
- **Chemotherapy**: The deductible applies.
- **Chiropractic Treatments**: There is a maximum of 40 visits in a calendar year and up to 52 annual chiropractic and physical therapy visits combined, subject to review and approval by the Claims Administrator. The deductible applies under the Non-Network and OOA options
- **Dental Services**: The removal of bony impacted, or partially bony impacted wisdom teeth are covered under the Medical Plan.. When Dental services are Covered Health Services and are performed in a hospital, the appropriate copays will apply.
- **Drugs** (drugs and medicines that are Covered Health Services and prescribed for you while you're in the hospital.): The deductible applies under the out of area and OOA options
- **Emergency Transportation**: Emergency transportation charges for a professional ambulance to and from a hospital or for an air ambulance to the nearest hospital qualified to give required treatment are covered for life-threatening illness, accident, or injury, or if pre-authorized by The Claims Administrator. There is a $4,000 limit under the Non-Network and OOA options.
- **Emergency Treatment**: Under the Network option you pay a $50 copayment if you are not admitted to the hospital and if the care received is retrospectively determined not to be an emergency, services will be covered at the non-network benefit level. The deductible applies to Non-Network and OOA options.
- **Eye Care**: The Medical Plan covers eye treatments that are Covered Health Services such as eye surgery but not expenses associated with a vision therapy program. The deductible applies to the Non-Network and OOA options. Routine vision care services such as exams, refractions, eyeglasses, and contact lenses are covered through the Vision Plan, and not by the Medical Plan.
- **Gynecological Exams**: including annual exams and Pap smears, based on AMA guidelines. The OOA option pays 100% of R&C charges with no deductible.

    - Note: POS option participants may go to a Network gynecologist once a year for a well-woman visit without referral from the PCP. For a subsequent visit to a gynecologist during the year, a referral from a PCP is required to receive the maximum benefit.
- **Hearing**: the Medical Plan pays up to $1,000 every three years toward hearing appliances.
- **Home Health Care**:
    - For Network referred services, home health care is covered in full with no copayment when your service is coordinated through the Claims Administrator's Case Management.
    - For Non-Network services there is an 80 visits limit per calendar year for home health aide services (four hours counts as one visit) and 120 visits in a calendar year for nursing or related skilled services (each visit counts as one visit, regardless of the length of the visit).
    - The OOA Option pays for Covered Health Services, if provided through a licensed, certified home health agency for up to 200 visits per year. The following are some examples:
        - Skilled, temporary care by an RN or LPN;
        - Temporary or part-time care by a home health aide (excluding custodial care);
        - Physical therapy;
        - Occupational therapy; and
        - Speech therapy.
    - The following home health care expenses will be covered to the extent that they would have been covered if the person had stayed in the hospital:
        - Medical supplies;
        - Drugs and medications ordered by a physician other than those available through the Prescription Drug Program; and
        - Laboratory services given or ordered by a hospital.
- **Hospice Care:** provided the attending physician has certified that the patient is terminally ill with six months or less to live. Services for the patient must be given in an inpatient hospice facility or in the patient's home.
- **Hospital Services:** For network referred hospital services, you pay $250 per admission with a maximum of three copayments per calendar year; under the Non-Network and the OOA options, the deductible applies. Covered services include:
    - Room and board charges for a semiprivate room or ward, or an intensive care unit.
    - Charges for a private room, when the patient's diagnosis, condition or treatment makes such charges a Covered Health Service.
    - Emergency room services.
    - Other services and supplies.
- **Immunizations:** covered through age 17, based on AMA guidelines. The OOA option pays 100% of R&C.
- **Infertility:** Charges for the diagnosis and treatment of infertility and charges for assisted reproductive technology, including in vitro fertilization. Total benefits for infertility and assisted reproductive technology are limited to $10,000 per lifetime for medical expenses in addition to $10,000 per lifetime for prescription drugs procured through the Prescription Drug program or other sources.
- **Mammograms:**
    - One baseline mammogram at age 40.
    - One mammogram every two years between ages 40 and 49.
    - One mammogram every year at or after age 50.

    - The Medical Plan Network option covers diagnostic mammograms at 100% of R&C charges when referred by the PCP, regardless of your age.
- **Medical Equipment Rentals or Purchase:** The charges for rental or initial purchase (or necessary repair) of durable medical equipment prescribed by a physician for treatment of an illness or injury are covered. Under the Network option, charges must be coordinated through the Claims Administrator's Home Care Department to be fully covered. Coverage does not include any changes made to the covered person's home, automobile, or personal property, such as air conditioning or remodeling. Equipment rental coverage is limited to the purchase price of the durable medical equipment.
- **Medical Supplies:** The following are some examples of medical supplies covered under the plan, provided they are Covered Health Services:
    - Prescribed drugs and medicines received in a hospital, as well as surgical supplies such as bandages and dressings.
    - An appliance to replace a lost body organ or part to help a disabled person return to functioning capacity – for example, an artificial limb or eye. Only the charge for the first appliance in the patient's lifetime is covered for each body organ or part, except for replacements needed due to a change in the patient's physical condition (including normal physical growth).
    - Custom-made, orthotics that meet the definition of a Covered Health Service..
    - Oxygen and the charges for giving it, including rental of required equipment.
- **Nursing Services (Including Private Duty):** The services of an RN or LPN, given in a hospital or through a home health care agency. To be covered, services under the Non-Network and OOA options require pre-certification from the Claims Administrator's Case Management.
- **Obstetrical and Newborn Care in the Hospital:** For network services, you pay a $250 copayment for all hospital services.
- **Occupational Therapy:** Medical care and treatment by an occupational therapist. For network services, a $20 copayment applies.
- **Office Visits:** Non-network, 70%; ONA, 80%
- **Organ Transplants:** The Medical Plan pays expenses for charges incurred:
    - By the transplant recipient and donor, if both are covered by the Medical Plan.
    - By the transplant recipient and donor, if only the recipient is covered under the Medical Plan provided the donor is not otherwise eligible for these benefits under any other plan. Benefits provided to the donor will be charged against the recipient's coverage under this policy.
    - By the donor, if only the donor is covered under the Medical Plan, provided the donor is not eligible for these benefits under any other plan.
    - If a transplant cannot be provided in your area, the Transplant Services program through the United Resource Network Facility will pay travel expenses for you and a companion.
- **Pap Smears:** Under the OOA option, payment is 100% of R&C
- **Physicals:**
    - Adult health screenings – Under the Non-Network option, physicals are not covered. If you are age 40 to age 49, the Medical Plan pays benefits for an exam every other year. If you are age 50 or older, the Medical Plan pays benefits for an annual physical.
    - Pediatric/well-child care – through the age of 17. The deductible applies under the Non-Network and OOA options.
- **Physical Therapy:** Under the Network option, there is a $20 copayment per visit. There is a maximum of 40 visits each calendar year and up to 52 chiropractic and physical therapy visits combined, subject to review and approval by the Claims Administrator. In general,

these limits on physical therapy do not apply to children under age 17. Under the Non-Network and OOA options the deductible applies.
- **Physicians' or Surgeons' Services**
- **Prenatal and Postnatal Care:** The deductible applies under the Non-Network and OOA options.
- **Psychiatric/Psychology Services:** Refer to *Mental Health / Chemical Dependency* section.
- **Radiology**
- **Speech Therapy:** Services of a qualified Speech Therapist, when prescribed by an attending physician, the services are not educational in nature and services are expected to result in significant physical improvement in the condition within two months of the start of treatment.; Pre-certification is required and the deductible applies under the Non-Network and OOA options.
- **Surgery:**
- **Vision Therapy:** For evaluation and development of a vision treatment plan for training by an optometrist or orthoptic technician. The deductible applies under the Non-Network and OOA options.
- **X-Rays**

What's Not Covered

As with most medical plans, the SNET Medical Plan does not cover certain expenses. Here are some examples:
- A treatment that doesn't normally require payment.
- A work-related injury or illness covered under Workers' Compensation.
- Acupuncture.
- All services or supplies which, in the opinion of the Claims Administrator, are determined not to be Covered Health Services.
- Autologous blood donation and storage.
- Charges for services, treatment, drugs, or devices that do not meet the definition of Covered Health Services.
- Charges for semen as part of infertility treatment (including collection and storage). Charges for compensation to an egg donor as a part of assisted reproductive technology program.
- Charges for procedures related to actual or attempted impregnation or fertilization or pregnancy of a surrogate mother other than health services or other charges relating to the pregnancy of a person covered under the Plan.
- Charges or services rendered by a physician or other provider to himself or herself or for services rendered to his or her immediate family, including parents, spouse, and children.
- Charges for weight loss clinics or programs, diet counseling, and special diets.
- Charges for any procedure to restrict the intake of food or other nutritional material or to divert the passage of such material through the digestive tract, including but not limited to gastric bypass, gastric balloons, jejunal bypass, laparoscopic banding and stomach stapling.
- Convenience or personal comfort items.
- Contraceptives other than oral contraceptives which do not meet the definition of Covered Heath Services.
- Correction of malposition of the teeth and jaw, or pain, deformity, deficiency, injury, or physical condition of the teeth.
- Cosmetic surgery except for reconstructive surgery resulting from injuries due to an accident or to correct a functional impairment from a birth defect or disease.

- Custodial care.
- Education, training, and bed and board while confined in an institution which is mainly a school or other institution for training, a place for the aged, or a nursing home.
- Exercise equipment or devices.
- Expenses above the reasonable and customary (R&C) charge.
- Expenses for you or your Dependent (including hospital confinement) that began before you or your Dependent was covered by the Medical Plan.
- Expenses for educational therapy, marital counseling, sex therapy, weight control programs, nutritional programs, and exercise programs.
- Expenses for failure to keep a scheduled appointment.
- Expenses for medical care that are reimbursed under auto insurance.
- Eyeglasses and eye refractions, unless required by accidental injury or surgery.
- Immunizations unless for children up to age 17.
- Injury or sickness caused by war or intentional armed conflict.
- Orthopedic shoes for adults.
- Personal services when you are in the hospital (TV rentals, telephone charges, guest meals, and so on).
- Post-mastectomy bras.
- Prescription drugs dispensed on an outpatient basis.
- Private duty nursing unless it's approved by the Medical Plan.
- Procedures determined by the Medical Plan to be Experimental or Investigational.
- Reversal of a tubal ligation or vasectomy.
- Routine medical and vision care.
- Services administered by a licensed pastoral counselor to a member of his or her congregation in the course of normal duties as a pastor or minister.
- Supplies and equipment that do not meet the definition of Covered Health Services such as air conditioners, bed trays and tables, humidifiers, orthopedic shoes (unless for a child through age 12), and bras (post-mastectomy).
- Surgery and treatment to alter gender.
- Tests for pre-marital or pre-employment examination.
- Therapeutic massage and general massages, including services provided by a health spa.

If an item or service is not on the list of either covered expenses or non-covered expenses, the Claims Administrator should be consulted prior to incurring the expense to determine whether or not the item or service will be covered.

Note: Certain expenses not covered by the Medical Plan *may* be eligible for reimbursement under the Health Care Flexible Spending Account, a special account that you can fund with before-tax dollars. Please refer to the **Flexible Spending Accounts SPD** for details.

Prescription Drugs Benefits

The Prescription Drug Plan provides benefits for the Network, Out of Network and the OOA plan options. You and your eligible Dependents are **automatically** enrolled in the Prescription Drug Plan when you enroll in any of theses medical plans. Both retail and mail order programs are available. The Prescription Drug Program is administered by Caremark, see *Contact*

Information. You may purchase covered prescriptions or supplies (up to a 30 day supply) at a participating retail network pharmacy using your drug card. For maintenance prescriptions or supplies – those requiring more than a 30-day supply – the mail order prescription program provides up to a 90-day supply per order. Prescriptions and supplies purchased through the participating pharmacy retail network are subject to a small co-pay. No claim forms are required. Prescriptions and supplies may also be purchased from non-participating pharmacies. Such purchases require full payment and submission of a claim form for reimbursement.

What is Covered

Covered prescription drugs include FDA approved medicine required by federal law to be dispensed only with a doctor's prescription and are dispensed subject to the professional judgment of the dispensing pharmacist, limitations imposed on controlled substances and the manufacturers recommendations.

Prescriptions for anorexiant medications, used in the treatment of obesity, require participation in the Claim Administrator's AdvancedCare Program for weight management and must be pre-certified into the program before prescriptions are dispensed. Contact the Prescription Drug Claims Administrator for details.

All over the counter drugs are excluded except for injectible insulin, diabetic supplies such as blood testing aids and diagnostic urine test and hypodermic needles and syringes for use with covered injectibles if prescribed by a doctor.

Exclusions

- Contraceptive Devices
- Contraceptive Injectables
- Diet Medications
- Hair Loss Drugs (Propecia)
- Infertility (in excess of the $10,000 lifetime maximum)
- Nutritional and Diet Supplements
- Toxoids
- Vaccines
- Ostomy Supplies
- Respiratory Therapy and other Prescription Devices
- Renovia

The following require a diagnosis before dispensing

- Retin A, if for a participant age 26 or over
- Smoking Cessation Products
- Viagra

Retail Prescription Purchase Program

Members receive a Caremark Prescription Drug identification card (two cards per covered member) for prescription drug purchases under the Retail Prescription Drug Program.

For retail prescription drugs, your benefits are paid based on whether or not your prescription is filled at a participating pharmacy. If your prescription is filled at a participating pharmacy, then you pay only the applicable co-payment for up to a 31-day supply of a drug or 100 units, whichever is greater, with no restrictions on refills (except as limited by your doctor's original prescription and applicable state or federal laws). The copayment you pay depends on whether the prescription is for a generic or brand drug. No claim form is required when you use your Prescription Drug identification card at a participating retail pharmacy.

If you use a non-participating pharmacy, or if you do not present your prescription drug identification card at a participating pharmacy, you will be required to pay full price for the prescription and submit a claim form in order to be reimbursed. Reimbursements will be the 50% of the cost of the drug.

Claim forms must be submitted for reimbursement to the prescription drug program Claims Administrator.

Mail Order Prescription Purchase Program

If you are prescribed a medication requiring long term use, you can take advantage of the mail order program. Instead of filling a prescription at a retail pharmacy, you may order up to a 90 day supply of prescription drugs through the mail service prescription drug program. Ask your physician for two prescriptions. The first, for a 14 day supply, can be filled using your drug card at a participating pharmacy. The second, for a 90 day supply, can then be filled through the mail order program.

A maximum of a 90-day supply of covered drugs and medicines per prescription or refill shall be dispensed by the mail order drug program administrator, subject to the professional judgment of the dispensing pharmacist, limitations imposed on controlled substances, and the manufacturer's recommendations.

Prescriptions will not be filled or refilled in the following instances:

- For all covered drugs except controlled substances, more than 12 months after issuance;
- For controlled substances, more than six (6) months after issuance; or
- If prohibited by applicable law or regulation.

Your prescription is reviewed by a pharmacist, checked against your patient profile and dispensed and verified by the administrator’s quality control department. Your order is normally shipped to you via U.S. mail to arrive within 14 days of the day you mailed your prescription.

The following drugs cannot be purchased through the mail service program:

- Drugs that require constant refrigeration during shipment;
- Drugs that cannot be shipped due to size, weight, fragility or other factors, and
- Drugs unsuitable for self-administration, including, but not limited to, diagnostic agents.

Questions concerning both the Retail and Mail Order Prescription Drug programs may be directed to the Prescription Drug Claims Administrator. They will answer your questions about:

- Refilling an existing mail order prescription;
- Covered drugs;

- Status of a mail order request;
- Identifying a participating pharmacy in your area; and
- Obtaining mail order envelopes and claim forms.

The mail service program can reduce your out-of-pocket expenses for prescription drugs that are used over an extended period. To use the program: Complete the patient profile questionnaire with your first order. Complete the order envelope. Enclose the written prescription and either the generic or brand-name copay for each prescription.

Schedule of Prescription Drug Benefits

Retail Purchases		**Mail Order Purchases**
At participating pharmacies, using your drug card. (Up to a 31 day supply or 100 units whichever is greater)	At non-participating pharmacies or participating pharmacies without the drug card	Through the Mail Order Program (30 to 90 day supply)
Deductible None Copayment: Generic Drugs $0 Brand $10	Deductible None Reimbursment: All drugs, an amount equal to the retail price less the applicable copayment.	Deductible None Copayment Generic Drugs $0 Brand $10

Behavioral Health Benefits

Applicable to the POS, and the OOA Plan Options

Behavioral health benefits are provided through a Network of Behavioral health counselors, doctors and facilities. These providers are managed through a national Behavioral Health Claims Administrator. You receive maximum benefits for Behavioral hHealth care when you use a participating provider and are pre-certified for certain types of care.

***To receive any benefits, you must pre-certify, before admission, any inpatient care for mental health care or chemical dependency by calling the Behavioral Health Claims Administrator, United Behavioral Health at* 1-800-538-8101 .** In the case of an emergency admission, you must call the Behavioral Health Claims Administrator within 24 hours of the admission. When you pre-certify your hospital stay, the Behavioral Health Claims Administrator will refer you to one of its participating providers. You receive maximum benefits when you use participating providers.

When you use a participating provider or facility, you will not need to file a claim form with the Behavioral Health Claims Administrator.

Inpatient or Outpatient Care

Benefits for behavioral health care vary depending on whether you or a covered Dependent are receiving care as a hospital inpatient or as an outpatient. Outpatient care can take place at a clinic or doctor's office.

You can receive benefits for covered expenses for Clinically Indicated treatment of mental health and chemical dependency care. ("Clinically Indicated") means care that meets all the following criteria:

- Adequate and essential therapeutic response provided for evaluation or treatment consistent with the symptoms;
- Proper diagnosis and treatment appropriate for the individual's illness;
- Disease or condition as defined by standard diagnostic nomenclatures (DSM-1V or its equivalent in ICD-9-CM);
- Reasonably expected to improve an individual's illness, condition or level of functioning;
- Safe and effective according to nationally accepted standard clinical evidence generally recognized by mental health or chemical dependency care professionals or publications; and
- Appropriate and cost-effective level of care that can safely be provided for the individual's diagnosed condition in accordance with professional and technical standards.

To receive any benefits, you must pre-certify, before admission, any inpatient care for mental health care or chemical dependency by calling the Behavioral Health Claims Administrator.. In the case of an emergency admission, you must call the Behavioral Health Claims Administrator within 24 hours of the admission. When you pre-certify your hospital stay, the Behavioral Health Claims Administrator will refer you to one of its participating providers. You receive maximum benefits when you use participating providers.

Alternative to Behavioral Health Inpatient Care: When pre-certifying for inpatient care, the Behavioral Health Claims Administrator may suggest alternative treatment options instead of inpatient care.

Psychological Testing Benefit – Benefits for psychological testing are paid at the same rate as outpatient Mental Health Benefits with the $15 copay applied per hour. All psychological testing must be pre-certified by calling the Behavioral Health Claims Administrator, regardless of the provider you use. Only the number of hours pre-certified by the Behavioral Health Claims Administrator is paid.

Approved Providers You'll want to verify that your provider's credentials meet the Behavioral Health Claims Administrator's requirements for reimbursement. Approved providers include:

- Licensed Professional Counselor;
- Licensed Marriage, Family and Child Counselor;
- Licensed Doctoral-level Psychologist (Ph.D., Ed.D., Psy.D.);
- Licensed Psychiatric Nurse with a Master of Science in Nursing and an RN license;
- Licensed Master's prepared Social Worker (some states may have additional requirements or may certify rather than license these professionals); and
- Licensed Marriage and Family Therapist (LMFT).

Schedule of Behavioral Health Benefits

Mental Health and Chemical Dependency Services

Inpatient or partial inpatient services: For services by network providers, you pay a $125 copayment per admission, with a maximum of three copayments per calendar year. For services by non-network providers, the behavioral health plan pays 70% of R&C charges. There is a maximum of 60 days coverage for mental health admissions and 45 days for chemical dependency. All inpatient admissions must be pre-certified. Failure to do so will result in a denial of benefits. Failure to precertify Non-Network outpatient services will result in a $500 reduction in benefits.

Outpatient services: For services by Network providers, the behavioral health plan pays 100% after a $30 copay per visit (first 20 visits per year) and $40 copay (for visits 21 and over.) For services by non-network providers, the behavioral health plan pays 50% of R&C .

Out-of-pocket chemical dependency expenses do not count toward the deductible or out-of-pocket maximum for other types of expenses.

Maximum Inpatient Limits

- 60 days per year inpatient mental health treatment (in and out of network combined)
- 45 days per year for inpatient chemical dependency treatment, (in and out of network combined)

Behavioral Health Benefits

Mental Health Benefits	**Network Providers**	**Non-Network Providers**
Outpatient First 20 visits Visits 21 and over	 100% after $30 copay per visit 100% after $40 copay per visit	 50% of R&C charges if precertified
Inpatient	100% after $125 copay per admission; 60 days per year maximum (in and out of network combined)	70% of R&C charges, if precertified; 60 days per year maximum (in and out of network combined)
Chemical Dependency Benefits	**Network Providers**	**Non-Network Providers**
Outpatient First 20 visits Visits 21 and over	 100% after $30 copay per visit 100% after $40 copay per visit	 50% of R&C charges if pre-certified
Inpatient	100% of contracted rate after $125 copay per admission. 45 days maximum per person per calendar year (in and out of network combined)	70% of R&C if precertified. 45 days maximum per person per calendar year (in and out of network combined)

Additional Exclusions and Limitations

Certain behavioral health expenses are not covered, including, but not limited to, the following:

- Academic education during residential treatment;
- Administrative psychiatric services when these are the only services rendered
- (for example, expert testimony and medical records review and maintenance);
- Aversive treatment;
- BEAM (Brain Electrical Activity Mapping);
- Bioenergetic therapy;
- Carbon dioxide therapy;
- Chemical dependency treatment involving nutritionally-based therapies,
- Non-abstinence-based treatment or aversion therapy, or individual therapy without a structured outpatient treatment program unless *ValueOptions* determines that such services are Clinically Indicated for the treatment of a DSM-W Mental Disorder or its equivalent in lCD-9CM;
- Confrontation therapy;
- Consultation with a mental health professional for adjudication of marital, child support and custody court cases;
- Court-ordered psychiatric or substance abuse treatment unless *ValueOptions* determines that such service is Clinically Indicated for the treatment of a DSM-TV Mental Disorder or its equivalent in 1CD-9CM;
- Crystal healing treatment;
- Cult deprogramming;
- Eating disorder and gambling programs based solely on the 12-Step Model;
- Educational evaluation and therapy;
- Environmental ecology treatments;
- EST (Erhard Seminar Training) or similar motivational services;
- Evaluations, consultations, testing or therapy for educational, professional training, or for investigation purposes relating to employment insurance, judicial or administrative roceedings;
- Experimental or Investigation therapies;
- Expressive therapies (for example, art, poetry, movement and psychodrama) as separately billed services;
- EMDR (Eye Movement Desensitization and Reprocessing);
- Guided imagery;
- Hemodialysis for schizophrenia;
- Hyperbaric or normobaric oxygen therapy;
- L-tryptophan and vitamins, except thiamine injections on admission for alcoholism, when there is a diagnosed nutritional deficiency;
- Marathon therapy;
- Marriage counseling except when rendered in connection with a DSM-1V Mental Disorder or its equivalent in ICD-9CM;
- Megavitamin therapy;
- Narcotherapy with LSD;
- Non-abstinence based or nutritionally based chemical dependency treatment;
- Orthomolecular therapy;

- Prescription drugs except when dispensed by a hospital, residential treatment center or day treatment program to a covered individual who, at the time of dispensing, is receiving treatment at the appropriate facility or program;
- Primal therapy;
- Rolfing;
- Sedative action electrostimulation therapy;
- Sex therapy (without a DSM-lV diagnosis or its equivalent in ICD-9CM);
- Supervision of treatment team;
- Transcendental meditation;
- Treatment for personal or professional growth, development, treating or professional certification;
- Treatment or consultation provided via telephone unless *ValueOptions* determines that such services are Clinically Indicated for the treatment of a DSM-1V Mental Disorder of its equivalent in ICD-9CM;
- Treatments or testing for mental retardation, autism, pervasive developmental disorders, chronic organic brain syndrome, learning disability or transsexualism unless *ValueOptions* determines that such services are Clinically Indicated for the treatment of a DSM-lV Mental Disorder or its
- equivalent in ICD-9CM; and
- Z-therapy, also known as "holding therapy".