YOUR GROUP HEALTH BENEFITS

Cameron County

Revised September 1, 2006

NOTICE

This Booklet describes Your employer's Employee Benefit Plan.

Major Medical Benefits are administered in accord with Your employer's self-funded plan of benefits. Claims are paid in accord with an Administrative Services Agreement between United of Omaha Life Insurance Company and Your employer.

HOW TO OBTAIN PLAN BENEFITS

To obtain benefits see the Payment of Claims provision. If You need assistance with filing Your claim or an explanation of how Your claim was paid, please refer to the toll-free number and address shown on Your identification card or contact Your Plan Administrator.

IMPORTANT NOTICE

This Booklet contains certain Utilization Management Provisions and a Preferred Provider option. These provisions affect the way benefits are paid to You. It is important that You refer to the SCHEDULE for the details.

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SELF FUNDED PLAN COVERAGE

Major Medical Benefits are self funded by Cameron County. Claims are administered in accord with Administrative Services Agreement which is comprised of Group Identification Number G00059K1 and Plan Identification Number MEDPPO, between United of Omaha Life Insurance Company and Cameron County.

Coverage is provided for certain employees as described in this Booklet.

The coverages described in this Booklet are subject to the terms and conditions of the Plan Document. In the event of any conflict with the provisions outlined in this Booklet and those in the Plan Document, the provision of the Plan Document will prevail.

The coverage is effective only if You and Your dependent(s) are eligible for the coverage, become covered and remain covered as described in this Booklet.

This Booklet replaces any previous Booklet issued under the Plan.

EMPLOYEE ELIGIBILITY

Active Employees

Eligible Employees

You are eligible on the day following completion of 30 days' continuous active employment with Us.

You are eligible as long as:

(a) you are a regular full-time employee of Ours;

(b) you are and continue to be actively employed; and

(c) you receive compensation for your work from Us for your work for Us.

NOTE: If you were eligible for coverage under the prior group plan but did not elect coverage, you may enroll in this Plan if you provide evidence of good health. If evidence is acceptable to United of Omaha, United will determine the date coverage begins.

Active Employment and Actively Employed means working 19 hours or more a week at your:

(a) regular job; and

(b) customary place of employment or other location to which you must travel to perform your regular job.

When Your Coverage Begins

You will become covered on the first day of the Plan month which coincides with or follows the day you become eligible, provided you are actively at work on that day. If you are not actively at work on that day, your coverage will begin on the first day of the Plan month which coincides with or follows the day you return to active work.

Exceptions

1. If, on the day your coverage is to begin:

   (a) you are on a regular paid day of vacation; or

   (b) such day is a regular non-working day;

   you will still be considered actively at work if you were available for work on the last preceding regular work day.

2. If, on the day your coverage is to begin you do not report to work, you will be considered actively at work if you are available for work on that day.

3. If your customary place of employment is at your home, you will be considered actively at work if you are not confined on that day (as described in the Confinement Rule below).

Confinement Rule

If you are:

(a) hospital confined;

(b) confined in any institution/facility other than a hospital due to an injury or sickness; or

(c) confined at home and under the supervision of a physician;

coverage will begin on the first day of the Plan month which coincides with or follows the day after such confinement ends.

If you are an active employee and you are not:

(a) confined; and

(b) available for work because of injury or sickness;

coverage will begin on the first day of the Plan month which coincides with or follows the day you return to active work.

Pre-existing Conditions

This Plan contains a Pre-existing Condition provision which is explained under the Major Medical Benefits. Please read this provision carefully since it may affect the way benefits are paid.

Amount of Coverage

The amount of coverage for your classification is shown in the Schedule.

Changes in Your Classification or in the Amount of Your Coverage

Any changes in your classification or coverage will take effect on the first day of the Plan month which coincides with or follows the day of the change provided you are actively at work on that day. If you are not actively at work, the following conditions will apply:

(a) If the change involves an increase in coverage, the change will not take effect until the first day of the Plan month which coincides with or follows the day you return full-time to your regular job.

(b) If the change involves a decrease in coverage, the change will take effect on the day of the change.

When Your Coverage Ends

Your coverage will end at midnight on the earliest of:

(a) the day the Plan ends;

(b) the day any premium for your coverage is due and unpaid;

(c) the day before you enter the Armed Forces on active duty (except for temporary active duty of two weeks or less); or

(d) the last day of the Plan month in which you are no longer eligible under the Plan.

You will no longer be eligible when the earliest of the following occurs:

(a) You are not in an eligible classification described in the Schedule;

(b) Your employment with Us ends;

(c) You have not been Actively Employed for a period of 90 consecutive days. This 90 days will run concurrently with any time period during which Your coverage remains in force in accordance with the Family and Medical Leave provision of the Plan; or

(d) You do not satisfy any other eligibility condition described in the Plan.

However, upon uninterrupted payment of premium to United of Omaha, You may be eligible to continue Your coverage in accordance with the continuation provisions.

Continuation of Coverage

If You are unable to meet the requirements for hours worked due to being disabled, You will continue to be eligible under the Plan until the earlier of:

(a) 90 days from the date the disability began;

(b) the date disability benefits payable under Our sick leave program has ended; or

(c) the date We terminate Your employment.

Refer to the COBRA Group Health Coverage Continuation provision found later on in this Booklet for other circumstances for which Your health coverage may be continued.

You should contact Us to determine the amount of contribution, if any, You are required to make in order to continue Your coverage.

EMPLOYEE ELIGIBILITY

Retired Employees

Eligible Employees

You are eligible, for retirement:

(a) after 30 years of service (at any age);

(b) at age 60 and after 15 years of service;

(c) after combined age and service credit (each rounded down to whole years) of 75 or more (Rule of 75);

(d) after combined age and service credit (each rounded down to whole years) of 80 or more (Rule of 80); or

(e) if You retire due to a work related disability, the minimum years of service requirement is 8 years.

When Your Coverage Begins

If United of Omaha receives Your signed written request on, before or within 31 days from the day You become eligible, You will become covered on the later of:

(a) the first day of the Plan month which coincides with or follows the day You become eligible; or

(b) the day we receive Your request.

Amount of Coverage

The amount of coverage for Your classification is shown in the Schedule.

Changes in Your Classification or in the Amount of Your Coverage

Any changes in Your classification or coverage will take effect on the first day of the Plan month which coincides with or follows the day of the change.

When Your Coverage Ends

Your coverage will end at midnight on the earliest of:

(a) the day the Plan ends;

(b) the day any premium for Your coverage is due and unpaid;

(c) the day before You enter the Armed Forces on active duty (except for temporary active duty of two weeks or less); or

(d) the last day of the Plan month in which You are no longer eligible under the Plan.

You will no longer be eligible when You do not satisfy any other eligibility condition in the Plan.

However, upon uninterrupted payment of premium to United of Omaha, You may be eligible to continue Your coverage in accord with the following continuation provisions. You should contact Us to determine the amount of contribution, if any, You are required to make in order to continue Your coverage.

Continuation of Coverage

Your coverage will be continued until You attain age 65, provided:

(a) You had 30 years of service (at any age);

(b) You are age 60 and after 15 years of service;

(c) after combined age and service credit (each rounded down to whole years) of 75 or more (Rule of 75);

(d) after combined age and service credit (each rounded down to whole years) of 80 or more (Rule of 80); or

(e) if You retire due to a work related disability, the minimum years of service requirement is 8 years.

FAMILY AND MEDICAL LEAVE

as Federally Mandated
For Active Employees

Family and Medical Leave

If You become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) (including any amendments to such Act) Your coverage may be continued on the same basis as if You were an Actively at Work employee for up to 12 weeks during the 12 month period, as defined by Us, for any of the following reasons:

(a) to care for Your child after the birth or placement of a child with You for adoption or foster care; so long as such leave is completed within 12 months after the birth or placement of the child;

(b) to care for Your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or

(c) for Your own serious health condition.

In the event You or Your spouse are both covered as employees of Ours, the continued coverage under (a) may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of 12 weeks.

Conditions

1. If, on the day Your coverage is to begin, You are already on an FMLA leave of absence You will be considered Actively at Work. Coverage for You and any eligible dependents will begin in accordance with the terms of the Plan. However, if Your leave of absence is due to Your own or any eligible dependent's serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.
2. You are eligible to continue coverage under FMLA if:
   (a) You have worked for Us for at least one year;
   (b) You have worked at least 1,250 hours over the previous 12 months;
   (c) We employ at least 50 employees within 75 miles from Your worksite; and
   (d) You continue to pay any required premium for Yourself and any eligible dependents in a manner determined by Us.
3. In the event You choose not to pay any required premium during Your leave, Your coverage will not be continued during the leave. You will be able to reinstate Your coverage on the day You return to work, subject to any changes that may have occurred in the Plan during the time You were not covered. You and any covered dependents will not be subject to any evidence of good health requirement provided under the Plan. Any partially-satisfied waiting periods, including any limitations for a preexisting condition, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.

4. You and Your dependents are subject to all conditions and limitations of the Plan during Your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.
5. If requested by United of Omaha, You or Cameron County must submit proof acceptable to United of Omaha that Your leave is in accordance with FMLA.
6. This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the Plan following the day Your FMLA continuation ends.
7. FMLA continuation ends on the earliest of:
   (a) the day You return to work;
   (b) the day You notify Us that You are not returning to work;
   (c) the day Your coverage would otherwise end under the Plan; or
   (d) the day coverage has been continued for 12 weeks.

Definitions

Prior Group Plan means the group plan providing similar benefits (whether insured or self-insured including HMO's and other prepayment plans provided by Us) in effect immediately prior to the effective date of this Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Serious Health Condition is defined as stated in the FMLA.

Important Notice

Contact Us for additional information regarding FMLA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS

as Federally Mandated
For Active Employees

Definitions

Health Coverage means hospital, surgical, medical, dental, vision, or prescription drug coverage provided under the Plan. Health Coverage is subject to change as a result of open enrollments or plan modifications.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such ACT and any interpretive regulations or rulings).

Service in the Uniformed Services means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

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

Continuation of Group Health Coverage

1. **For You and Your Eligible Dependents**: If Health Coverage ends because of Your service in the Uniformed Services, You may elect to continue such Health Coverage, if required by USERRA, until the earlier of:
   (a) the end of the period during which You are eligible to apply for reemployment in accordance with USERRA; or
   (b) 24 consecutive months after coverage ended.
2. To continue coverage, You or Your dependent must pay the required premium, (including Your former employer's share and any retroactive premium), unless Your service in the Uniformed Service is for fewer than 31 days, in which event You must pay Your share, if any, of the premium. The Plan Administrator will inform You or Your dependent of procedures to pay premiums.
3. **End of Continuation**. A Covered Person's continued Health Coverage will end at midnight on the earliest of:
   (a) the day Your former employer ceases to provide any group health plan to any employee;
   (b) the day premium is due and unpaid;
   (c) the day a Covered Person again becomes covered under the Plan;

(d) the day Health Coverage has been continued for the period of time provided in part 1.(a) or (b) above (or any longer period provided in the Plan); or

(e) the day the Plan terminates.

Any Health Coverage for an eligible dependent will also end as provided in the "When Dependents Coverage Ends" provision of the Plan.

4. **Other Continuation Provisions.** In the event Health Coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or in part by Us, then the premium You are required to pay may increase for the remainder of the period provided above.

Reemployment (following service in the Uniformed Services)

Following Your discharge from such service, You may be eligible to apply for reemployment with Your former employer in accord with USERRA. Such reemployment includes Your right to elect reinstatement in any then existing health coverage provided by Us.

Important Notice

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by Us or Your former employer, will apply.

DEPENDENTS ELIGIBILITY

Health Coverage - Active Employees

Eligible Dependents

Only the following are eligible for dependents coverage:

(a) Your lawful spouse;

(b) Your natural-born or legally adopted child;

(c) Your stepchild who is living in your home and is chiefly dependent on you for support; and

(d) A foster child.

A foster child is:

(1) a child you are raising as your own;
(2) a child who lives in your home;
(3) a child who is chiefly dependent on you for support; and
(4) a child for whom you have taken full parental responsibility and control.

A foster child is not:

(1) a child temporarily living in your home;
(2) a child placed with you in your home by a social service agency which retains control of the child; or
(3) a child whose natural parent is in a position to exercise or share parental responsibility and control.

Adopted Child (As Federally Mandated by OBRA 93)

A minor child, under the age of 18, placed with You for the purpose of legal adoption will be covered from the moment the child is placed in Your custody.

Coverage for such child will not continue beyond 31 days of placement unless any required premium has been paid to us before that 31st day.

The child's coverage will continue subject to any required premium until the earlier of:

(a) the day the child is removed from Your custody prior to legal adoption; or

(b) the day coverage would otherwise end in accordance with the Plan provisions.

Any Preexisting Conditions Limitations shown in the Plan will not apply.

Definition

Placed for adoption means assumption and retention by the Covered Person of a legal obligation for total or partial support of such child in anticipation of adoption of such child.

This provision is in addition to any other Adopted Child provision contained in the Plan.

When the parents of a child are covered under the Plan as employees or members, the child can be covered only as a dependent of one parent.

Dependents Not Eligible

The following are not eligible for dependents coverage:

(a) Your divorced spouse or any married child;

(b) A child who has been legally adopted by another person shall not be considered an eligible dependent, (Coverage ends on the date custody is assumed by the adoptive parents);

(c) Anyone eligible for coverage under the Plan as an employee or member (unless a Special Husband/Wife Provision is included in the Plan); or

(d) A child who has attained the **limiting age.** The limiting age is:
   (1) the child's **19th birthday;** or
   (2) the **25th birthday** if the child is a full-time student in any accredited high school, trade school, college or university and is chiefly dependent on you for support.

Handicapped Child

The coverage for a mentally or physically handicapped child who attains the limiting age while covered under the Plan may be continued if the child:

(a) is chiefly dependent on you for support; and

(b) is not capable of self-sustaining employment.

The coverage will continue only if you give us proof of the child's handicap:

(a) no later than 31 days after the child attains the limiting age; and

(b) thereafter as United of Omaha may require, but not more often than once every two years.

The First Enrollment Period

If you want to cover your eligible dependents, you must make a written request for dependents insurance. If United of Omaha receives the signed written request to enroll your dependents on, before or within 31 days from the day you become eligible, your dependents coverage will begin the same day your coverage begins.

Once you have a dependent covered, any newly acquired eligible dependent will be covered automatically if no additional premium is required. If additional premium is required, coverage for a newly acquired dependent will not begin until United of Omaha receives written request in accord with the above paragraph and the premium is paid.

NOTE: If your dependents were eligible for coverage under the prior group plan but were not enrolled, you may elect dependent coverage under this Plan, subject to evidence of good health for each dependent. If evidence is acceptable to United of Omaha, United will determine the day coverage begins.

Subsequent Enrollment Periods

Annual open enrollment periods will be allowed in which you may elect or change your dependent's benefits. The annual group enrollment period is designated by Us and agreed to by United of Omaha, but, in no event more than 31 calendar days.

If you waived medical coverage for your dependents during any enrollment period, you may elect dependent medical benefits during any subsequent enrollment period, subject to evidence of good health. If evidence is acceptable to United, United will determine the day coverage begins. No evidence of good health will be required if your dependents were covered by another plan sponsored medical plan immediately preceding selection of our plan at open enrollment. Your dependents will become covered for coverage on the following September 1, subject to the Confinement/Disability Rule below.

You may decrease or decline dependent coverage during any subsequent enrollment period.

Exceptions

(a) Newborn children. Your newborn child, born while you are covered under the Plan, will automatically be covered; but coverage beyond 31 days for a newborn child will be continued only if any required premium is paid.

(b) Confinement/Disability Rule. Coverage for a dependent who:
   (1) is hospital confined;
   (2) is confined in any institution or facility (other than a hospital) or at home or elsewhere due to an injury or sickness; or
   (3) is disabled, either physically or mentally, to the extent of:
      a. being unable to perform all of the usual and customary duties and activities (the "normal activities") of a person of the same age and sex who is in good health; and/or
      b. not being able to engage in any work or occupation for wages or profit;

   will not take effect in the case of paragraphs (1) or (2) above, until such confinement ends, and/or is no longer medically necessary, as determined by our medical staff and/or an independent medical review, and in the case of paragraph (3) above, until the full resumption of all normal activities and/or return to active work.

   This Confinement/Disability Rule does not apply to a child born while you are covered under the Plan.

Medical Child Support Order (As Federally Mandated by OBRA 93)

If Your eligible child is not covered because You did not enroll Your child for dependents coverage, such child may be enrolled after we: (a) receive a final medical child support order which requires enrollment and (b) determine that the order is qualified.

United of Omaha's Procedures for Determining if a Medical Child Support Order is Qualified. When a proposed or final medical child support order is received, United will notify You and each child named in the order, at the addresses shown in the order, that it has been received. United will then review the order to decide if it meets the definition of a "qualified medical child support order". Within 30 days after the order is received (or within a reasonable time thereafter), You will be sent a written notice of the decision for You and each child named in the order. Notices will be sent to each attorney or other representative who may be named in the order or in other correspondence filed with United. If a

decision is made that the order is not qualified, the notice will provide the specific reasons for the decision and the opportunity to correct the order or appeal the decision by contacting United within 30 days. If a decision is made that the order is qualified, the notice will provide instructions for enrolling each child named in the order; and the Plan provisions that apply for other eligible dependents (such as the exceptions for when dependents coverage begins and the rules for determining when dependents coverage ends) will also apply for each child named in the order. United of Omaha must receive a certified copy for the entire "qualified medical child support order" before enrollment can occur. Also, if the cost of each child's coverage is to be deducted from Your pay, United must receive proper authorization in the order or otherwise.

As part of the authority to interpret the Plan, United has the discretion and final authority to decide if an order meets or does not meet the definition of a "qualified medical child support order" so as to require the enrollment of Your child as an eligible dependent; and United's reasonable decision will be binding and conclusive on all persons. If, as a result of an order, benefits are paid to reimburse medical expenses paid by a child or the child's custodial parent or legal guardian these benefits will be paid to the child or the child's custodial parent or legal guardian.

United of Omaha will treat each child enrolled because of a "qualified medical child support order" as a participant for purposes of the reporting and disclosure requirements of a federal law known as ERISA.

The Definition of "Qualified Medical Child Support Order". A "qualified medical child support order" is defined by Section 609 of ERISA. In general, a **"Qualified Medical Child Support Order"** means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

(a) either: (1) relates to medical benefits under the Plan and provides for Your child's support or health benefit coverage pursuant to a state domestic relations law (including a community property law); or (2) enforces a law relating to medical child support described in Section 1908 of the Social Security Act;

(b) creates or recognizes the existence of Your child's right to be enrolled and receive medical benefits under the Plan;

(c) states the name and last known mailing address (if any) of You and each child covered by the order;

(d) reasonably describes the type of medical coverage to be provided by the Plan to each child, or the manner in which this type of coverage is to be determined;

(e) states the period to which the order applies;

(f) states each Plan to which the order applies; and

(g) does not require the Plan to provide any type or form of benefit or any option not otherwise provided by the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act for medical child support orders.

When Election Changes Are Permitted

We have chosen to provide these benefits to Dependents under a Section 125 Cafeteria Plan. A Cafeteria Plan permits Employees to elect to pay your Dependents' share of the benefit cost with pre-tax deferrals. Such Cafeteria Plans permit You to change Your pre-tax deferral election only when certain specific events occur (other than during an enrollment period.) You have 31 days from the date of the event to submit a written request to Us regarding any such events. The Plan Administrator will provide You with information regarding the election changes that are permissible under Our Cafeteria Plan.

If Your election change does not meet Section 125 Cafeteria Plan requirements, You may only make an election change during a Subsequent Enrollment Period.

If You make a request to begin Dependents coverage within 31 days after an event, coverage will become effective on the first day of the first calendar month following United of Omaha's receipt of the enrollment request, or on an earlier date, as agreed to by United.

If You make a request to begin Dependents coverage more than 31 days after any event, You may only elect Dependents coverage during a Subsequent Enrollment Period.

If You make a request to end Dependents coverage under this Plan within 31 days after an event, Dependents coverage will end in accordance with the When Dependents Coverage Ends provision.

When Dependents Coverage Ends

A dependent's coverage will end at midnight on the earliest of:

(a) the last day of the policy month the dependent is no longer eligible;

(b) the day any dependent premium is due and unpaid;

(c) the day the Plan ends;

(d) the day before a dependent enters the Armed Forces on active duty (except for temporary active duty of two weeks or less);

(e) the day dependents coverage under the Plan ends because of lack of participation; or

(f) the day your coverage ends.

NOTE: Your covered spouse and/or any insured dependent child may also elect to continue health coverage when eligibility ends. See COBRA GROUP HEALTH COVERAGE CONTINUATION provision found later on in this Booklet. In the event more than one continuation provision applies, the periods of continued coverage will run concurrently.

DEPENDENTS ELIGIBILITY

Health Coverage - Retired Employees

Eligible Dependents

Only the following are eligible for dependents coverage:

(a) Your lawful spouse;

(b) Your natural-born or legally adopted child;

(c) Your stepchild who is living in Your home and is chiefly dependent on You for support; and

(d) A foster child.

A **foster child is:**

(1) a child You are raising as Your own;
(2) a child who lives in Your home;
(3) a child who is chiefly dependent on You for support; and
(4) a child for whom You have taken full parental responsibility and control.

A **foster child is not:**

(1) a child temporarily living in Your home;
(2) a child placed with You in Your home by a social service agency which retains control of the child; or
(3) a child whose natural parent is in a position to exercise or share parental responsibility and control.

Adopted Child (As Federally Mandated by OBRA 93)

A minor child, under the age of 18, placed with You for the purpose of legal adoption will be covered from the moment the child is placed in Your custody.

Coverage for such child will not continue beyond 31 days of placement unless any required premium has been paid to us before that 31st day.

The child's coverage will continue subject to any required premium until the earlier of:

(a) the day the child is removed from Your custody prior to legal adoption; or

(b) the day coverage would otherwise end in accordance with the Plan provisions.

Any Preexisting Conditions Limitations shown in the Plan will not apply.

Definition

Placed for adoption means assumption and retention by the Covered Person of a legal obligation for total or partial support of such child in anticipation of adoption of such child.

This provision is in addition to any other Adopted Child provision contained in the Plan.

When the parents of a child are covered under the Plan as employees or members, the child can be covered only as a dependent of one parent.

NOTE: If Your dependents were eligible for coverage under any prior group plan provided by the Cameron County but did not elect coverage, You may enroll Your dependents in this Plan only if evidence of good health is provided to us for such dependents. If such evidence is acceptable to United of Omaha, United will determine the date coverage begins.

Dependents Not Eligible

The following are not eligible for dependents coverage:

(a) Your divorced spouse or any married child;

(b) A child who has been legally adopted by another person shall not be considered an eligible dependent, (Coverage ends on the date custody is assumed by the adoptive parents);

(c) Anyone eligible for coverage under the Plan as an employee or member; or

(d) A child who has attained the **limiting age.** The limiting age is:
   (1) the child's **19th birthday;** or
   (2) the **25th birthday** if the child is a full-time student in any accredited high school, trade school, college or university and is chiefly dependent on You for support.

Handicapped Child

The coverage for a mentally or physically handicapped child who attains the limiting age while covered under the Plan may be continued if the child:

(a) is chiefly dependent on You for support; and

(b) is not capable of self-sustaining employment.

The coverage will continue only if You give us proof of the child's handicap:

(a) no later than 31 days after the child attains the limiting age; and

(b) thereafter as we may require, but not more often than once every two years.

When Dependents Coverage Begins

If You want to cover Your eligible dependents, You must make a written request for dependents coverage. If the request is made before You are eligible for coverage, dependents coverage will begin the same day You are covered. If the request is made within 31 days after You are eligible for coverage, dependents coverage will begin the day we receive the request.

If You do not have a dependent until after You are covered, You must make Your written request no later than 31 days from the date You acquire the dependent. Coverage for that dependent will begin the later of:

(a) the date we receive Your request; or

(b) the date You acquired the dependent.

Once You have a dependent covered, any newly acquired eligible dependent will be covered automatically if no additional premium is required. If additional premium is required, coverage for a newly acquired dependent will not begin until we receive written request in accord with the above paragraph and the premium is paid.

If You make a written request to cover a dependent after the 31-day limit, You must furnish evidence acceptable to us that each dependent You wish to cover is in good health. If the evidence is acceptable to us we will determine the date dependents coverage begins.

If You want to reinstate any dependents coverage after You have let it lapse, You must furnish evidence acceptable to us that each dependent You wish to cover is in good health. We will determine the date dependents coverage begins.

Exceptions

(a) Newborn children. Your newborn child, born while You are covered under the Plan, will automatically be covered; but coverage beyond 31 days for a newborn child will be continued only if any required premium is paid.

(b) Confinement/Disability Rule. Coverage for a dependent who:
   (1) is hospital confined;
   (2) is confined in any institution or facility (other than a hospital) or at home or elsewhere due to an injury or sickness; or
   (3) is disabled either physically or mentally, to the extent of:
      a. being unable to perform all of the usual and customary duties and activities (the "normal activities") of a person of the same age and sex who is in good health; and/or
      b. not being able to engage in any work or occupation for wages or profit;

   will not take effect in the case of paragraphs (1) or (2) above, until such confinement ends and/or is no longer medically necessary, as determined by our medical staff and/or an independent medical review, and in the case of paragraph (3) above, until the full resumption of all normal activities and/or return to active work.

   This Confinement/Disability Rule does not apply to a child born while You are covered under the Plan.

Medical Child Support Order (As Federally Mandated by OBRA 93)

If Your eligible child is not covered because You did not enroll Your child for dependents coverage, such child may be enrolled after we: (a) receive a final medical child support order which requires enrollment and (b) determine that the order is qualified.

United of Omaha's Procedures for Determining if a Medical Child Support Order is Qualified. When a proposed or final medical child support order is received, United will notify You and each child named in the order, at the addresses shown in the order, that it has been received. United will then review the order to decide if it meets the definition of a "qualified medical child support order". Within 30 days after the order is received (or within a reasonable time thereafter), You will be sent a written notice of the decision for You and each child named in the order. Notices will be sent to each attorney or other representative who may be named in the order or in other correspondence filed with United. If a decision is made that the order is not qualified, the notice will provide the specific reasons for the

decision and the opportunity to correct the order or appeal the decision by contacting United within 30 days. If a decision is made that the order is qualified, the notice will provide instructions for enrolling each child named in the order; and the Plan provisions that apply for other eligible dependents (such as the exceptions for when dependents coverage begins and the rules for determining when dependents coverage ends) will also apply for each child named in the order. United of Omaha must receive a certified copy for the entire "qualified medical child support order" before enrollment can occur. Also, if the cost of each child's coverage is to be deducted from Your pay, United must receive proper authorization in the order or otherwise.

As part of the authority to interpret the Plan, United has the discretion and final authority to decide if an order meets or does not meet the definition of a "qualified medical child support order" so as to require the enrollment of Your child as an eligible dependent; and United's reasonable decision will be binding and conclusive on all persons. If, as a result of an order, benefits are paid to reimburse medical expenses paid by a child or the child's custodial parent or legal guardian these benefits will be paid to the child or the child's custodial parent or legal guardian.

United of Omaha will treat each child enrolled because of a "qualified medical child support order" as a participant for purposes of the reporting and disclosure requirements of a federal law known as ERISA.

The Definition of "Qualified Medical Child Support Order". A "qualified medical child support order" is defined by Section 609 of ERISA. In general, a **"Qualified Medical Child Support Order"** means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

(a) either: (1) relates to medical benefits under the Plan and provides for Your child's support or health benefit coverage pursuant to a state domestic relations law (including a community property law); or (2) enforces a law relating to medical child support described in Section 1908 of the Social Security Act;

(b) creates or recognizes the existence of Your child's right to be enrolled and receive medical benefits under the Plan;

(c) states the name and last known mailing address (if any) of You and each child covered by the order;

(d) reasonably describes the type of medical coverage to be provided by the Plan to each child, or the manner in which this type of coverage is to be determined;

(e) states the period to which the order applies;

(f) states each Plan to which the order applies; and

(g) does not require the Plan to provide any type or form of benefit or any option not otherwise provided by the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act for medical child support orders.

Change in the Amount of Dependents Coverage

Any change in the coverage of a dependent who is confined or disabled (as described in the Confinement/Disability Rule above) will not take effect:

(a) in the event of an increase in coverage, until such confinement or disability ends; or

(b) in the event of a decrease in coverage, on the day of the change.

When Dependents Coverage Ends

A dependent's coverage will end at midnight on the earliest of:

(a) the last day of the Plan month the dependent is no longer eligible;

(b) the day any dependent premium is due and unpaid;

(c) the day the Plan ends;

(d) the day before a dependent enters the Armed Forces on active duty (except for temporary active duty of two weeks or less);

(e) the day dependents coverage under the Plan ends because of lack of participation; or

(f) the day Your coverage ends.

NOTE: Your covered spouse and/or any covered dependent child may also elect to continue health coverage when eligibility ends. See COBRA GROUP HEALTH COVERAGE CONTINUATION provision found later on in this Booklet. In the event more than one continuation provision applies, the periods of continued coverage will run concurrently.

SCHEDULE

THIS SCHEDULE DESCRIBES THE DEDUCTIBLE, COPAYMENTS, COINSURANCE, MAXIMUM BENEFITS AND CERTAIN OTHER REQUIREMENTS AND LIMITATIONS APPLICABLE TO BENEFITS FOR COVERED SERVICES. UNITED OF OMAHA'S OBLIGATION TO CONSIDER BENEFITS IS SUBJECT TO ALL TERMS AND CONDITIONS OF THE PLAN, INCLUDING, BUT NOT LIMITED TO, ALL DEFINITIONS, GENERAL EXCLUSIONS AND LIMITATIONS, AND PLAN CHANGES. PLEASE REFER TO THE TABLE OF CONTENTS TO LOCATE THESE PROVISIONS.

Benefits under the Plan for You and Your dependents will be in accordance with Your classification in this Schedule.

Classification(s)

All eligible active employees

All eligible retired employees

UTILIZATION MANAGEMENT PROVISIONS

In order to provide cost effective health coverage, the Plan contains the following Utilization Management Provisions:

Utilization Review
Case Management Program

NOTE: A complete description of these provisions can be found in the Utilization Management Provisions section of this Booklet. We urge You to read these provisions thoroughly. Some of the provisions provide more favorable benefits if the requirements and procedures described in the provisions are followed.

IN SOME INSTANCES, LESS FAVORABLE BENEFITS ARE PROVIDED IF THE REQUIREMENTS OR PROCEDURES DESCRIBED IN THE UTILIZATION MANAGEMENT PROVISIONS ARE NOT FOLLOWED.

PREFERRED PROVIDER OPTION

The Plan includes a Preferred Provider Option.

When You and Your dependents require health care, You may choose any Physician, Hospital or other health care provider You wish. However, if You use the services of a Preferred Provider, health coverage benefits may be subject to a more favorable Deductible, Percentage Payable or Out-of-Pocket Limit (as shown in this Schedule). Regardless of the provider You choose, benefits will be subject to all other terms, conditions and limitations of the Plan.

For the purposes of this Schedule and other provisions of the Plan, the following terms have the following meanings:

Other Provider means a provider of Covered Services who is not currently participating in United's Preferred Provider network.

Preferred Provider means a provider of Covered Services who is currently participating in United's Preferred Provider network.

United will publish a list of Preferred Providers periodically. The provider information is also available through United's website at www.mutualofomaha.com. Your Plan Administrator will furnish You with a list of Preferred Providers, as a separate document, without charge.

United makes every effort to maintain current and accurate provider data. However, periodic changes to provider status can occur. From time to time, providers will be added to the network or may discontinue their participation. It is important You understand that the provider list and website are being updated as United receives new information about providers and that provider's may not be participating in the network at all locations they provide services. Providers with multiple addresses are considered participating only at the address(es) listed. Not all providers at a clinic or physician group are participating in the network. Not all facility-based physicians are participating in the network.

Because of this, You and Your dependent should confirm with the provider, before receiving treatment:

- That the provider is still participating in the network;
- If the provider is participating at the address or location the services are being provided;
- If the provider at the clinic or physician group is participating - not just that the clinic or physician group is participating; and/or;
- If the facility-based physicians are participating providers in the network.

If a provider is not participating in the network at the time of treatment, the Covered Services will be considered at the non-participating provider benefit level.

The provider list does not contain information about Your specific plan of benefits. Some participating providers may not be available to You and Your dependents due to the Plan provisions. Please review this document thoroughly as there may be limitations on benefits or access to specific providers and/or services.

All Preferred Providers and Other Providers are independent contractors; they are not United's employees or agents. United does not supervise, control or guarantee the outcome or results of any health care services furnished by any Preferred Provider or Other Provider. Your and Your dependent's relationship with a Preferred Provider or Other Provider is that of provider and patient. The Preferred Provider or Other Provider is solely responsible for the health care services provided to You and Your dependents.

United's payments to Preferred Providers will be in accordance with United's arrangements with such providers.

NOTE: You may find a list of United's Medical Specialty Network providers, Specialty Pharmacy Providers and providers of home medical products and services by searching United's directory of national and regional suppliers who provide discounts on United's website at www.mutualofomaha.com.

DISCOUNTED CHARGES

United of Omaha Life Insurance Company (United) has contractual arrangements with Preferred Providers and other health care providers, provider networks, pharmacy benefit managers, and other vendors of health care services and supplies ("Providers"). In accordance with these arrangements, certain Providers have agreed to Discounted Charges.

A "Discounted Charge" is the amount that a Provider has agreed to accept as payment in full for covered health care services or supplies. A Discounted Charge does not include pharmaceutical rebates or any other reductions, fees or credits a Provider may periodically give United. United will retain those amounts that are not Discounted Charges. However, United has estimated the amount of such rebates, reductions, fees and credits and has taken those into consideration in setting the fees charged to provide services under this Plan.

Claims under the Plan and any Deductible, Copayment (based upon percentage of charges), Coinsurance and benefit Maximums as described in the Plan will be determined based on the Discounted Charge.

For You and Your Dependents
HEALTH COVERAGE

MAJOR MEDICAL BENEFITS

Definition

For the purposes of this Schedule, the following terms have the following meanings:

Calendar Year means January 1 through December 31 of the same year.

Coinsurance means the applicable percentage payable for Covered Services by the Covered Person after benefits have been considered by the Plan in accordance with the percentage payable provision in the Schedule.

Copayment Options

This plan may have multiple Copayments (as shown in this Schedule). In the event more than one Copayment for each provider could apply to one visit or Covered Service each day, only the largest Copayment will apply to that visit or Covered Service for that day.

Copayment means an amount payable at the time Covered Services are received.

If You and Your dependents are required to make a Copayment (not based on a percentage of charges) in order to receive a Covered Service, You and Your dependent will pay the lowest of (a) the Copayment; (b) the Discounted Charge; or (c) the provider's billed charge, subject to any applicable Usual and Customary Charge or Allowable Charge limitation.

Deductible

Individual Deductible

For Preferred Providers: $400 of Expense incurred by You and each of Your dependents for Covered Services of Preferred Providers. The Covered Person must satisfy the Individual Deductible once each Calendar Year.

For Other Providers: $1,000 of Expense incurred by You and each of Your dependents for Covered Services of Other Providers. The Covered Person must satisfy the Individual Deductible once each Calendar Year.

Family Deductible

For Preferred Providers: After $1,200 of Expense has been incurred by You and Your dependents for Covered Services of a Preferred Provider during a Calendar Year, no other Individual Deductible requirement shall apply.

For Other Providers: After $3,000 of Expense has been incurred by You and Your dependents for Covered Services of an Other Provider during a Calendar Year, no other Individual Deductible requirement shall apply.

NOTE: The same Expense may be used to satisfy the Deductible for Preferred Providers and Other Providers.

Exceptions

(a) Deductible Carry-over. The Deductible is reapplied on January 1 of each year. However, Expense applied towards the Deductible in the last 90 days of a Calendar Year will be applied towards the Deductible for the next Calendar Year.

(b) Waiver of the Deductible: The Deductible is waived for Covered Services in connection with:
- (1) a Preferred Provider's services for Routine Health Care Services (for Covered Persons age 18 or older);
- (2) a Preferred Provider's services for a Routine Mammography;
- (3) a Preferred Provider's services for Preventive Health Care (for dependent children through age 17);
- (4) a Preferred Provider's services for Childhood Immunization for eligible dependent children through age six;
- (5) Ambulance Services;
- (6) a Preferred Provider's services for Independent Radiology and Pathology Center Services;
- (7) a Preferred Provider's services for Urgent Care Center Services;
- (8) a Preferred Provider's services for Hospital Emergency Room Facility Services;
- (9) a Preferred Provider's services for Outpatient Facility Services;
- (10) services for covered Bassinet, Nursery and Well Newborn Delivery Hospital Services;
- (11) a Preferred Provider's services Allergy Injections;
- (12) a Preferred Provider's services for Routine Vision Care; and
- (13) services for covered Counseling and Bereavement Services.

(c) Copayments and/or Coinsurance percentage which the Covered Person pays will not be used to satisfy the Individual or Family Deductible.

Deductible means the amount payable for Covered Services by the Covered Person each Calendar Year before benefits are payable by the Plan.

Percentage Payable

All Covered Services shown in the Major Medical Benefits provision and not listed elsewhere in this Schedule will be payable as follows:

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense which You and Your dependents incur for Covered Services of Preferred Providers (and the Covered Person pays 20%) until the Out-of-Pocket Limit is reached.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense which You and Your dependents incur for Covered Services of Other Providers (and the Covered Person pays 40%) until the Out-of-Pocket Limit is reached.

Out-of-Pocket Limit

Individual Out-of-Pocket Limit

For Preferred Providers: After the Out-of-Pocket Expense by one Covered Person reaches $2,000, the Plan will pay 100% of the Expense for Covered Services of Preferred Providers incurred by such person during the rest of the Calendar Year.

For Other Providers: After the Out-of-Pocket Expense by one Covered Person reaches $5,000, the Plan will pay 100% of the Expense for Covered Services of Other Providers incurred by such person during the rest of the Calendar Year.

Family Out-of-Pocket Limit

For Preferred Providers: After the Out-of-Pocket Expense by You and Your dependents combined reaches $4,000, the Plan will pay 100% of the Expense which You and Your dependents incur for Covered Services of Preferred Providers incurred by such persons during the rest of the Calendar Year.

For Other Providers: After the Out-of-Pocket Expense by You and Your dependents combined reaches $10,000, the Plan will pay 100% of the Expense which You and Your dependents incur for Covered Services of Other Providers incurred for such persons during the rest of the Calendar Year.

NOTE: The same Out-of-Pocket Expense may be used to satisfy the Out-of-Pocket Limit for both Preferred Providers and Other Providers.

Exceptions

Expense for the following will not be used to satisfy the Individual or Family Out-of-Pocket Limit and will not be paid at 100% after the Individual or Family Out-of-Pocket Limit is reached:

(a) any Copayment which a Covered Person must pay;

(b) Mental and Nervous Disorders;

(c) Spinal Treatment (nonsurgical);

(d) any amount which the Covered Person must pay as a result of failure to comply with the Utilization Management Provisions; and

(e) Organ(s) Tissue Transplant services performed by a Preferred Provider or Other Provider who does not participate in United's **MSN**.

Out-of-Pocket Expense means Expense which the Covered Person incurs for Covered Services provided during the Calendar Year and must pay :

(a) as Coinsurance; and

(b) as Deductibles, except for Covered Services that apply to the Deductible, but do not apply toward the Out-of-Pocket Expense.

NOTE: Any Expense incurred for a non-covered service does not apply to the Out-of-Pocket Limit.

Maximum

Maximum Benefits under the Plan

$1,000,000 is the maximum amount of benefits payable under the Plan for Covered Services of Preferred Providers and Other Providers combined for treatment of all Injuries and Sicknesses of each Covered Person (the "Maximum").

NOTE: The same Expense will be used to accumulate toward both the Preferred Provider and Other Provider Maximum.

Benefits are payable only for Expense incurred while You and Your dependents are covered under the Plan.

Exception

The Maximum benefits payable under the Plan will be reduced by the amount of benefits immediately preceding this coverage that have been paid or that are payable under the group health plan (whether insured or self-insured) currently maintained by Us and through which You are currently covered.

Allergy Injections

For Preferred Providers: After a $25 Copayment for Preferred Providers is satisfied, the Plan will pay 100% of the Expense incurred for Covered Services.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services.

NOTE: Benefits for Covered Services incurred for allergy injections and allergy serum provided in and billed by a Physician's office are payable under this section of this Schedule.

Ambulance Services

For Preferred Providers: The Plan will pay 80% of the Expense incurred for Covered Services by a professional ambulance service.

For Other Providers: The Plan will pay 80% of the Expense incurred for Covered Services by a professional ambulance service.

Bassinet, Nursery and Well Newborn Delivery Services

Well Newborn

Covered Hospital Services

The Plan will pay benefits for the Expense incurred by a Covered Person who is a well newborn dependent child for bassinet or nursery charges in the same manner as any other covered Hospital Confinement service. No Deductible will apply.

Covered Physician Services

Expense for Physician services incurred by such child during the Hospital Confinement will be payable same as any other Sickness as shown under the Physician Services section of this Schedule.

Sick Newborn

Covered Hospital and Physician Services

Benefits for Expense incurred by a covered sick newborn will be payable same as any other Sickness.

Chemical Dependency Benefits

Refer to the Chemical Dependency Benefits shown in the Major Medical Benefits section of this Booklet.

Childhood Immunization Services (For Dependent Children through age six)

Maximum Immunization Benefit

For Preferred Providers: The Plan will pay 100% of the Expense incurred for Covered Services received for Childhood Immunizations.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services received for Childhood Immunizations.

NOTE: Immunizations for dependent children age 7 through 17 are payable under the Preventive Health Care Services (For Dependent Children through age 17) section of this Schedule.

Dental Services Due To a Dental Injury

The Plan will pay benefits for Expenses incurred for dental procedures, including, but not limited to crowns, bridges, orthodontia, due to a Dental Injury as follows:

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services provided by a Physician or Dentist for a Dental Injury.

For Other Providers: In the same manner as for Preferred Providers.

NOTE: Dental exams received in the office and any associated dental x-rays are payable under the Physician Services Office Visit Copayment. All other dental procedures are payable under this section of the Schedule.

Durable Medical Equipment

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received for Durable Medical Equipment each Calendar Year.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services received for Durable Medical Equipment each Calendar Year.

Maximum Durable Medical Equipment Benefit

The Maximum Durable Medical Equipment Benefit for Other Providers will not exceed $5,000 while You and Your dependents are covered under the Plan.

High End Radiology

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received for High End Radiology performed on an outpatient basis.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services received for High End Radiology performed on an outpatient basis.

High End Radiology means a magnetic resonance imaging (MRIs), magnetic resonance angiogram (MRAs), computerized tomography scan (CT Scans), positron emission tomography scan (PET Scans), single photon emission computed tomography scan (SPECT Scans), ultrasounds and other nuclear radiology.

NOTE: Benefits for High End Radiology tests performed in a Physician's office, Independent Radiology and Pathology Center, Outpatient Facility and Emergency Room will be payable under this section of the Schedule.

Home Health Care Services

Each Visit Payment

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Home Health Care visits.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred, up to a Maximum Allowable Amount of $40 for each visit.

Maximum Number of Visits

The Maximum Number of Visits for which benefits are payable each Calendar Year will not exceed 100 for Preferred Providers and Other Providers combined each Calendar Year.

Maximum Allowable Amount means the total charge considered for Covered Services before the applicable Deductible and Coinsurance amounts are applied. In cases where the Usual and Customary Charge is less than the Maximum Allowable Amount, the Usual and Customary Charge would apply.

Hospice Care Services (inpatient and outpatient)

Inpatient

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for inpatient Hospice Care.

Inpatient Daily Limit: The daily room charge of the Hospice Care Facility or other facility where the Covered Person is confined.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred, up to a Maximum Allowable Amount of $40 per day.

Outpatient

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received for Hospice Care.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred, up to a Maximum Allowable Amount of $40 for each visit.

Inpatient and Outpatient Daily Limit

For Other Providers: The Inpatient and Outpatient Daily Limit will not exceed a combined Maximum Allowable Amount of $40.

Maximum Number of Days and Visits

The combined Maximum Number of Days and Visits for which benefits are payable will not exceed 185 for Preferred Providers and Other Providers combined.

Covered Counseling and Bereavement Services
Maximum Counseling Benefit

The Plan will pay 100%, up to $500 for all members of the Covered Person's Immediate Family combined.

Maximum Bereavement Counseling Benefit

The Plan will pay 100%, up to $250 for all members of the Covered Person's Immediate Family combined.

Maximum Allowable Amount means the total charge considered for Covered Services before the applicable Deductible and Coinsurance amounts are applied. In cases where the Usual and Customary Charge is less than the Maximum Allowable Amount, the Usual and Customary Charge would apply.

Hospital Confinement Facility Services

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received for each Hospital Confinement.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services received for each Hospital Confinement.

Room Limit

Semiprivate Room: The semiprivate room charge of the Hospital where the Covered Person is confined.

Ward Accommodation: The ward accommodation charge of the Hospital where the Covered Person is confined.

Private Room: The average semiprivate room charge of the Hospital where the Covered Person is confined. If the Hospital/facility only has private rooms, the private room rate will be allowed.

Intensive Care Unit/Cardiac Care Unit: The intensive care unit/cardiac care unit charge of the Hospital where the Covered Person is confined.

Hospital Emergency Room Facility Services

Covered Hospital Services

For Preferred Providers: After a $50 per visit Copayment for Preferred Providers is satisfied, the Plan will pay 100% of the Expense incurred for Covered Services provided by a Hospital Emergency Room.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services provided by a Hospital Emergency Room.

NOTE: The Emergency Room Copayment is waived if the emergency room treatment is immediately followed by Hospital Confinement.

NOTE: Benefits for High End Radiology tests performed in the Emergency Room and billed by the Hospital will be payable as outlined under the High End Radiology section of the Schedule.

NOTE: Emergency Room Physician, x-ray and laboratory services that are billed separate from the Hospital services will be payable as outlined in the applicable Physician sections of the Schedule or Independent Radiology and Pathology Center Services sections of the Schedule.

Independent Radiology and Pathology Center Services

For Preferred Providers: The Plan will pay 80% of the Expense incurred for Covered Services provided by an Independent Radiology and Pathology Center.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services provided by an Independent Radiology and Pathology Center.

NOTE: Any Expense incurred for High End Radiology and Routine Mammography performed at and billed by an Independent Radiology and Pathology Center will be payable under the High End Radiology or Routine Mammography Services sections of this Schedule.

Independent Radiology and Pathology Center means a freestanding facility offering radiology and pathology service which:

(a) is not part of a Hospital; and

(b) is licensed by the proper authority in the jurisdiction in which it is located.

Inpatient Rehabilitation Facility Services

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received for inpatient rehabilitation therapy each Calendar Year.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services received for inpatient rehabilitation therapy each Calendar Year.

Maximum Inpatient Rehabilitation Facility Benefits

The Maximum Number of Days Payable for Preferred Providers and Other Providers combined will not exceed 60 days each Calendar Year.

Mental and Nervous Disorders Benefits

Maximum Inpatient Benefit (for Hospital Confinement)

Covered Hospital Services

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred.

All Other Covered Services

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred each Calendar Year. Benefits for visits by a Physician are payable only during the period of time that benefits for the Hospital Confinement are payable.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred each Calendar Year. Benefits for visits by a Physician are payable only during the period of time that benefits for the Hospital Confinement are payable.

Maximum Inpatient Benefits for Preferred Providers and Other Providers combined will not be payable for more than 30 days each Calendar Year. Benefits will not be payable for more than 60 days while You and Your dependents are covered under the Plan.

Maximum Outpatient Benefit

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred each Calendar Year.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred each Calendar Year.

Maximum Outpatient Benefits for Preferred Providers and Other Providers combined will not exceed 30 visits each Calendar Year.

Other Covered Services

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Other Covered Services not listed elsewhere in this Schedule.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Other Covered Services not listed elsewhere in this Schedule.

Outpatient Facility Services

For Preferred Providers: The Plan will pay 80% of the Expense incurred for Covered Services provided in an Outpatient Facility.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services provided in an Outpatient Facility.

NOTE: Benefits for High End Radiology, Routine Mammography and Outpatient Therapy services performed in and billed by an Outpatient Facility will be payable as outlined under the High End Radiology, Routine Mammography Services and Outpatient Therapy Services sections of this Schedule.

Outpatient Facility means a facility providing nonemergency services other than an Independent Radiology and Pathology Center, Urgent Care Center or Hospital Emergency Room.

Copayments

If a Participating Retail Pharmacy is used

For Diabetic Supplies

$5 for each Diabetic Supply which is included on the Drug Formulary

$25 for each Diabetic Supply which is not included on the Drug Formulary

For Covered Drugs (other than Diabetic Supplies)

$10 for each prescription or refill for a Generic Drug

$15 for each prescription or refill for a Brand Name Drug which is included on the Drug Formulary

$25 for each prescription or refill for a Brand Name Drug which is not included on the Drug Formulary

If You or Your dependents are required to make a Copayment (not based on a percentage of charges) in order to receive a covered Prescription Drug or supply, You or Your dependent will pay the lower of:

(a) the Copayment; or

(b) the pharmacy's charge.

For purposes of this provision, "pharmacy's charge" means the price or fee that would be charged by the pharmacy to You or Your dependent for a Prescription Drug or supply in a cash transaction on the date the Prescription Drug or supply is furnished or dispensed.

If a Non-Participating Retail Pharmacy is used

For Covered Drugs

50% of the Expense incurred for each prescription or refill or each Diabetic Supply

If a Participating Prescription-by-Mail (Mail Order) Pharmacy is used

For Diabetic Supplies

$10 for each Diabetic Supply which is included on the Drug Formulary

$50 for each Diabetic Supply which is not included on the Drug Formulary

For Covered Drugs (other than Diabetic Supplies)

$20 for each prescription or refill for a Generic Drug

$30 for each prescription or refill for a Brand Name Drug which is included on the Drug Formulary

$50 for each prescription or refill for a Brand Name Drug which is not included on the Drug Formulary

Outpatient Therapy Services

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received for outpatient therapy visits.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services received for outpatient therapy visits.

Maximum Number of Outpatient Therapy Visits

For Preferred Providers and Other Providers combined:

Physical Therapy and Occupational Therapy:

60 visits each Calendar Year for Physical Therapy and Occupational Therapy combined

Speech Therapy:

30 visits each Calendar Year

NOTE: Physical Therapy includes Aquatic Therapy and Osteopathic Manipulative treatment.

NOTE: Benefits will be payable for Expense incurred for outpatient therapy, including physical, occupational, speech, cardiac rehabilitation and pulmonary rehabilitation performed in a Physician's office, an Outpatient Facility or received during a Covered Home Health Care Visit. Physical, Occupational and Speech Therapies are subject to the Maximum Number of Outpatient Therapy Visits.

Physician Office Services

For Covered Services received in a Physician's office:

For Preferred Providers only: After the applicable office visit Copayment for Preferred Providers is satisfied, the Plan will pay 100% of the Expense incurred for Covered Services received in a Physician's office subject to the Conditions that follow.

Office Visit Copayment: $25

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services received in a Physician's office.

Conditions of Preferred Provider Office Services

1. Any Deductible shown in the Schedule will not apply.
2. These Conditions apply to services received in the Physician's office, including but not limited to:
   (a) services other than surgery:
      (1) office visits, including the initial office visit for the diagnosis of pregnancy;
      (2) consultation;

(3) Routine Health Care Services and Preventive Health Care Services as described in this Booklet;
(4) ophthalmology exam (excluding Routine Vision Care and refractions); and
(5) Medical Emergency office visits;

(b) injections (excluding allergy injections and Specialty Drugs and Medicines);

(c) allergy testing;

(d) radiation therapy; and

(e) x-ray and laboratory services (excluding other High End Radiology, such as MRIs, CT scans, PET scans, SPECT scans, arteriograms, ultrasounds and other nuclear medical scans).

These conditions do not apply to:

(a) services performed by an Other Provider;

(b) office surgery;

(c) supplies provided by the Physician;

(d) drugs supplied by the Physician;

(e) outpatient therapy;

(f) treatment for Mental and Nervous Disorders;

(g) treatment for Dependency;

(h) Spinal Treatment (nonsurgical);

(i) Allergy Injections;

(j) Specialty Drugs and Medicines;

(k) Routine Vision Care;

(l) High End Radiology; and

(m) subsequent office visits for maternity services, including prenatal and postnatal care, after the initial diagnosis of pregnancy.

NOTE: An office visit Copayment will apply to each Physician bill received.

NOTE: X-ray and laboratory tests that are performed outside the Physician's office or that are sent outside of the Physician's office for interpretation are payable under the Independent Radiology and Pathology Center Services, High End Radiology or Outpatient Facility Benefit as shown in the Schedule, depending on the type of service and where it is performed.

Physician Services for Inpatient Surgery

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services provided by a Physician for inpatient surgery.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services provided by a Physician for inpatient surgery.

Covered Physician surgical services are for the professional fees for surgical services provided by a Physician, including the services of an assisting surgeon.

Physician Services for Outpatient Surgery

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services provided by a Physician for outpatient surgery.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services provided by a Physician for outpatient surgery.

Covered Physician surgical services are for the professional fees for surgical services provided by a Physician, including the services of an assisting surgeon.

NOTE: Outpatient surgery includes surgical procedures performed in a Physician's office or in an outpatient facility.

Physician Nonsurgical Inpatient and Outpatient Services

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services provided by a Physician for nonsurgical inpatient and outpatient services.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services provided by a Physician for nonsurgical inpatient and outpatient services.

Covered Physician nonsurgical services are for the professional fees related to medical care (other than surgery) received in a Hospital, Skilled Nursing Facility, inpatient rehabilitation facility and Outpatient Facility.

Physician Services for Maternity Including Prenatal and Postnatal Care

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services provided by a Physician for maternity services for prenatal and postnatal care.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services provided by a Physician for maternity services for prenatal and postnatal care.

Preventive Health Care Services (For Dependent Children through age 17)

For Preferred Providers: After a $25 Copayment for Preferred Providers is satisfied, the Plan will pay 100% of the Expense incurred for Covered Services received for preventive health care, up to $300 each Calendar Year.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services received for preventive health care, up to $300 each Calendar Year.

Maximum Preventive Benefit

The maximum for which benefits are payable will not exceed $300 for Preferred Providers and Other Providers combined each Calendar Year.

Prosthetics

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received for prosthetics each Calendar Year.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services received for prosthetics each Calendar Year.

Maximum Prosthetic Benefit

The Maximum Prosthetic Benefit for Other Providers will not exceed $5,000 while You and Your dependents are covered under the Plan.

Qualified Organ(s)/Tissue Transplant Services

Maximum Recipient Benefit

For United's Medical Specialty Network Providers (**MSN)**: After the applicable Deductible for Preferred Providers is satisfied, The Plan will pay 80% of the Expense incurred for Covered Services received for Qualified Organ(s)/Tissue Transplant services.

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received for Qualified Organ(s)/Tissue Transplant services. The maximum benefit payable is $50,000 .

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 50% of the Expense incurred for Covered Services received for Qualified Organ(s)/Tissue Transplant services. The maximum benefit payable is $50,000 .

Maximum Donor Benefit

For each Transplant Surgery performed the Plan will pay:

Medical Specialty Network Providers: Donor benefits at 100%, up to $25,000

Preferred Providers: None

Other Providers: None

NOTE: The Percentage Payable for Preferred Providers and Other Providers does not apply to the Out-of-Pocket Limit and does not increase to 100% of eligible expense when the Out-of-Pocket Limit for Preferred Providers and Other Providers has been reached.

Medical Specialty Network Option (MSN)

United offers an optional program for Organ(s)/Tissue transplants called the **Medical Specialty Network**.

United's **MSN** consists of certain providers throughout the United States with whom United has contracted or made arrangements with to provide Organ(s)/Tissue Transplants.

United will work with You and Your Physician to determine which of the **MSN** providers is available for Your or Your dependent's type of transplant.

If a Qualified Organ/Tissue Transplant is Medically Necessary and performed at a **MSN**, You may be eligible for benefits related to Expenses for travel, lodging and meals for the transplant Recipient and one family member or Caregiver. The Plan may also assist You and one family member or Caregiver with travel and lodging arrangements.

Exceptions

(a) If You or Your dependent do not use United's **MSN**, any benefits under the **MSN** Option will not apply.

(b) Cornea transplants will be paid the same as any other Covered Service and are not eligible for benefits under the **MSN** Option.

Routine Health Care Services (For Covered Persons age 18 or older)

For Preferred Providers: After a $25 Copayment for Preferred Providers is satisfied, the Plan will pay 100% of the Expense incurred for Covered Services received for Routine Health Care Services, up to $300 each Calendar Year.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services received for Routine Health Care Services, up to $300 each Calendar Year.

Maximum Routine Benefit

The maximum for which benefits are payable will not exceed $300 for Preferred Providers and Other Providers combined each Calendar Year.

Routine Mammography Services

Maximum Routine Mammography Benefit

For Preferred Providers: The Plan will pay 100% of the Expense incurred for Covered Services.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services.

Routine Vision Care

Covered Vision Exam Services

For Preferred Providers: The Plan will pay 100% of the Expense incurred for Covered Services received for a vision exam, up to a Maximum Allowable Amount of $80 each Calendar Year.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services received for a vision exam, up to a Maximum Allowable Amount of $80 each Calendar Year.

Vision Exam Services means an eye examination to test the health of ones eyesight, including a refraction which is an assessment of the need for corrective lenses. This does not include fees for the fitting of contact lenses.

Maximum Number of Visits

The number of vision exams for which benefits are payable will not exceed one each Calendar Year for Preferred Providers and Other Providers combined.

Maximum Allowable Amount means the total charge considered for Covered Services before the applicable Deductible and Coinsurance amounts are applied. In cases where the Usual and Customary Charge is less than the Maximum Allowable Amount, the Usual and Customary Charge would apply.

Skilled Nursing Facility Services

Room Limit

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred each Calendar Year for the daily room charges of the Skilled Nursing Facility where the Covered Person is confined.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred each Calendar Year for the daily room charges of the Skilled Nursing Facility where the Covered Person is confined, up to a Maximum Allowable Amount of $150 per day.

Maximum Number of Days

The Maximum Number of Days payable for Preferred Providers and Other Providers combined will not exceed 100 days each Calendar Year.

Maximum Allowable Amount means the total charge considered for Covered Services before the applicable Deductible and Coinsurance amounts are applied. In cases where the Usual and Customary Charge is less than the Maximum Allowable Amount, the Usual and Customary Charge would apply.

Specialty Drugs and Medicines

Benefits for covered Specialty Drugs and Medicines supplied by Preferred Providers or Other Providers (excluding Specialty Pharmacy Providers) in a Physician's office or clinic or in a home health care setting are payable under this section of the Schedule.

NOTE: Benefits for covered Specialty Drugs and Medicines supplied through a Specialty Provider (at a retail pharmacy) are payable under the Outpatient Prescription Drug Benefits section of this Schedule.

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense which You and Your dependent incurred for Specialty Drugs and Medicines provided by Preferred Providers.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense which You and Your dependent incurred for Specialty Drugs and Medicines provided by Other Providers.

Specialty Drugs and Medicines means injectable drugs or medicines for the ongoing treatment of a chronic condition.

NOTE: Benefits for Specialty Drugs and Medicines received in a Hospital setting are payable under the Hospital Confinement Facility Services or Outpatient Facility Services sections of the Schedule.

Spinal Treatment (nonsurgical) Services

Maximum Spinal Treatment (nonsurgical) Benefit

For Preferred Providers: After the applicable Deductible for Preferred Providers is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services for nonsurgical Spinal Treatment provided by a Preferred Provider, but not to exceed:

(a) the Maximum Allowable Amount of $40 each visit; and

(b) a maximum of 30 visits each Calendar Year.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services for nonsurgical Spinal Treatment by an Other Provider, but not to exceed:

(a) the Maximum Allowable Amount of $40 each visit; and

(b) a maximum of 30 visits each Calendar Year.

The combined maximum number of visits for which benefits are payable will not exceed 30 visits for Preferred Providers and Other Providers combined each Calendar Year.

Maximum Allowable Amount means the total charge considered for Covered Services before the applicable Deductible and Coinsurance amounts are applied. In cases where the Usual and Customary Charge is less than the Maximum Allowable Amount, the Usual and Customary Charge would apply.

NOTE: Benefits for any Physical or Occupational Therapy performed during the same visit as the Spinal Treatment (non-surgical) Services, will be payable under the Outpatient Therapy section of the Schedule.

Urgent Care Center Services

For Preferred Providers: The Plan will pay 80% of the Expense incurred for Covered Services provided in an Urgent Care Center.

For Other Providers: After the applicable Deductible for Other Providers is satisfied, the Plan will pay 60% of the Expense incurred for Covered Services provided in an Urgent Care Center.

Urgent Care Center means a free-standing facility offering ambulatory medical service, which:

(a) is not part of a Hospital; and

(b) is licensed by the proper authority in the jurisdiction in which it is located.

MAJOR MEDICAL BENEFITS

For You and Your Dependents

Benefits

If You or Your dependent, while covered under this provision, incurs Expense for Covered Services described in this provision because of an Injury or Sickness, the Plan will pay a percentage of that Expense (Percentage Payable) after the applicable Deductible and Copayments are satisfied. Consideration of benefits is subject to all terms of the Plan including, but not limited to, all Definitions and General Exclusions and Limitations. Please refer to the Table of Contents in the Booklet to locate these provisions. The Plan will pay up to the Maximum for each Covered Person. The **Percentage Payable, Deductible** and **Maximum** are shown in the **Schedule** included in this Booklet.

Covered Services

1. **Covered Hospital Services**

   (a) Hospital room and board, up to the **Room Limit** shown in the **Schedule**;

   (b) Hospital services and supplies used when benefits are payable under (a) above;

   Hospital charges for the services of a Physician, private duty nurse or other practitioner are not covered under (a) or (b) above.

   (c) inpatient rehabilitation therapy services, up to the **Maximum Inpatient Rehabilitation Facility Benefits** shown in the **Schedule**;

   (d) Hospital outpatient services in connection with:
   (1) a surgical operation; or
   (2) emergency treatment after an Injury; and

   (e) preadmission tests only if:
   (1) the Covered Person's Physician determines before the tests are performed that Hospital Confinement is required;
   (2) the tests are performed:
   a. on an outpatient basis; and
   b. in connection with a Hospital Confinement which is a Covered Service;
   (3) the tests would be Covered Services if performed during Hospital Confinement; and
   (4) the Hospital where the Covered Person is confined:
   a. accepts the tests in lieu of tests which would have been performed during Hospital Confinement; and
   b. does not repeat the tests upon admission (unless the Covered Person's medical record shows both the results of the preadmission tests and that repeated tests are Medically Necessary).

2. **Covered Surgical Services**

   (a) Physician's services for a surgical operation, or the repair of a dislocation or fracture, including the services of an assisting surgeon;

(b) administration of anesthesia by persons not employed by the Hospital; or

(c) second opinion on the need for surgery when:
  (1) the opinion is given by a Physician who:
    a. is certified by the American Board of Medical Specialties, or another specialty board acceptable to United, in a field related to the proposed surgery; and
    b. is not the same Physician who first advised or recommended the surgery;
  (2) the Physician makes a personal exam of the Covered Person; and
  (3) the Physician sends United a written description of his/her opinion.

3. **Other Covered Services** (if not included in 1 or 2 above)

(a) Hospital outpatient services;

(b) Physician's services for medical care;

(c) outpatient therapy services for physical, occupational, speech, cardiac rehabilitation and pulmonary rehabilitation provided by a licensed therapist are payable up to the **Maximum Number of Outpatient Therapy Visits** shown in the **Schedule**;

(d) ambulance services for:
  (1) professional ambulance service when:
    a. transportation is Medically Necessary; and
    b. transportation is to the nearest Hospital equipped to furnish the services; and
  (2) transportation within the United States by a professional ambulance or on a regularly scheduled flight on a commercial airline when:
    a. such transportation is Medically Necessary; or
    b. special and unique Hospital Covered Services are required which are not provided by a local Hospital; and

(e) the following services and supplies:
  (1) drugs and medicines requiring a Physician's written prescription;
  (2) injectables, including Specialty Drugs and Medicines, not obtained through a retail pharmacy that are administered in a Physician's office or a home health care setting;
  (3) x-ray and laboratory service, including High End Radiology;
  (4) oxygen and the rental of equipment for its administration;
  (5) purchase or rental of equipment, not to exceed the purchase price (except for oxygen and the rental of equipment for its administration) of Durable Medical Equipment used for the treatment of an Injury or Sickness, up to the **Maximum Durable Medical Equipment Benefit** shown in the **Schedule**;
  (6) blood, blood products or blood plasma and its administration;
  (7) radium, radioactive isotopes and x-ray therapy, casts, splints, braces, trusses and crutches;
  (8) artificial limbs and eyes to restore or replace mobility of natural limbs and eyes up to the **Maximum Prosthetic Benefit** shown in the **Schedule**;
  (9) lens implant required because of cataract surgery;
  (10) dental services by a Physician or Dentist for the treatment of a Dental Injury to Sound Natural Teeth (including the initial replacement of the injured teeth and any necessary dental x-rays), provided the treatment plan begins within 90 days of the Injury and is completed within one year after the Injury; and

(11) specialized post-mastectomy or breast cancer surgery bras, not to exceed four (4) in any calendar year.

Definitions (applicable to Other Covered Services)

Dental Injury means an accidental Injury to Sound Natural Teeth which is the direct result of a sudden, unexpected and unintended external force, such as a blow or fall, that requires treatment by a Physician or Dentist. It must be independent of Sickness or any other causes. It does not include tooth breakage while biting or chewing.

Durable Medical Equipment means Medically Necessary equipment that is:

(a) able to withstand repeated or prolonged use;

(b) primarily and customarily used to serve a medical purpose;

(c) not generally useful to a person in the absence of Injury or Sickness; and

(d) is suited for use in the home.

Durable Medical Equipment includes supplies that are necessary for use with the equipment.

Durable Medical Equipment does not include motor vehicles or any modifications that do not serve a direct medical purpose in treating an Injury or Sickness, including but not limited to:

(a) modifications/assistive devices for motor vehicles (not including motorized wheelchairs or scooters used in lieu of wheelchairs); or

(b) internal or external structural modifications to buildings, widening of doorframes, replacement doors, ramps, modifications to walkways, stairs or non-bathroom hand-rails.

High End Radiology means a magnetic resonance imaging (MRIs), magnetic resonance angiogram (MRAs), computerized tomography scan (CT Scans), positron emission tomography scan (PET Scans), single photon emission computed tomography scan (SPECT Scans), ultrasounds and other nuclear radiology.

Sound Natural Teeth means teeth which:

(a) are whole or properly restored;

(b) are without impairment or periodontal disease; and

(c) are not in need of the treatment provided for reasons other than Dental Injury.

Specialty Drugs and Medicines means injectable drugs or medicines for the ongoing treatment of a chronic condition.

4. **Covered Skilled Nursing Facility Services**

Room and board, up to the **Room Limit** and **Maximum Number of Days** shown in the **Schedule** for a period of confinement in a Skilled Nursing Facility.

Conditions

The Plan will pay benefits for Skilled Nursing Facility services only if:

(a) the confinement is under the supervision of a Physician;

(b) Hospital Confinement would be necessary in the absence of Skilled Nursing Facility confinement; and

(c) the confinement is not considered to be Custodial Care by United.

Skilled Nursing Facility means a facility licensed or certified by the jurisdiction in which it is located, or eligible for payment under Medicare, that provides continuous inpatient skilled nursing care.

5. **Covered Home Health Care Services**

Covered home health care services consist of:

(a) nursing care provided on a part-time basis (less than an eight-hour shift) in a home by:
  (1) a registered nurse (RN); or
  (2) a licensed practical nurse; and

(b) part-time or intermittent Home Health Aide services provided in a home:
  (1) by a Home Health Aide; and
  (2) under the supervision of a registered nurse.

Benefits for home health care services are payable up to the **Maximum Number of Visits**, but not to exceed the **Each Visit Payment**, for each home health care visit. The **Maximum Number of Visits** and **Each Visit Payment** are shown in the **Schedule**.

One home health care visit consists of:

(a) one visit for the services listed; or

(b) up to four consecutive hours for Home Health Aide services.

Conditions

Home health care services must be provided by a person other than You, a person who lives in Your home or a member of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse); and covered home health care services and supplies must be ordered and directed by a Physician and furnished:

(a) in a private home;

(b) by a Home Health Agency; and

(c) in accordance with a Home Health Care Plan.

6. **Covered Hospice Care Services**

Hospice Care Services can provide the physical, psychological, spiritual or social support needed to help Terminally Ill Covered Persons cope with their Sickness. Hospice Care Services include services provided in accordance with a Hospice Care Plan in a private home, a Hospital or Hospice Care Facility. Benefits are payable as long as they are prescribed or ordered by a Physician and the Covered Person is Terminally Ill.

Benefits for inpatient Hospice Care Services will be payable:

(a) when Medically Necessary; and

(b) when there are no suitable Caregivers; or

(c) when it is determined by the Hospice Agency that Hospice care in a home is impractical because the patient is unmanageable by the persons who regularly assist with home care; or

(d) for Respite Care.

Benefits for outpatient Hospice Care Services will be payable:

(a) when Medically Necessary;

(b) for nursing care provided on a part-time basis (less than an eight-hour shift) by:
  (1) a registered nurse (RN); or
  (2) a licensed practical nurse; and/or

(c) for part-time or intermittent Home Health Aide services provided:
  (1) by a Home Health Aide; and
  (2) under the supervision of a registered nurse.

Hospice Care Services are payable up to the **Maximum Number of Days** and **Visits** shown in the **Schedule**.

Condition

Hospice Care Services must be provided by a person other than You, a person who lives in Your home or a member of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse).

7. **Covered Counseling and Bereavement Services**

When benefits for Hospice Care Services are payable, the Plan will also pay benefits for the Expense incurred for:

(a) counseling of the Covered Person and his or her Immediate Family, but not to exceed the **Maximum Counseling Benefit** shown in the **Schedule**; and

(b) Bereavement Counseling of the Covered Person's Immediate Family, but not to exceed the **Maximum Bereavement Counseling Benefit** shown in the **Schedule**.

Benefits for counseling and Bereavement Counseling for the Covered Person's Immediate Family members are payable whether or not the family members are covered under the Plan.

Benefits for Bereavement Counseling will be paid even if coverage ends before the counseling is received.

Condition

Counseling and Bereavement Counseling must be rendered by a Physician, psychologist or social worker.

Definitions (applicable to Home Health Care and/or Hospice Care Services)

Bereavement Counseling means counseling for the social, psychological and spiritual needs of the Immediate Family to cope with the loss of a Terminally Ill Covered Person.

Caregiver means a person not associated with the Hospice Agency who resides in the Covered Person's home and provides nonmedical services and companionship. This may not be a family member.

Home Health Agency means a public or private agency or organization appropriately licensed, qualified and operated under the law of the jurisdiction in which it is located.

Home Health Aide means a person who:

(a) provides care of a therapeutic nature; and

(b) reports to and is under the direct supervision of a Home Health Agency.

Home Health Care Plan means a written plan, approved in writing by a Physician, for continued care and treatment of a Covered Person:

(a) who is under the care of a Physician; and

(b) who would need continued Hospital Confinement or Skilled Nursing Facility confinement without the home health care.

Hospice means a program that:

(a) provides care to the Terminally Ill;

(b) is licensed/certified by the jurisdiction in which it operates;

(c) is supervised by a staff of Physicians with at least one Physician on call 24 hours a day;

(d) provides 24-hour a day nursing services under the direction of a registered nurse (RN) and has a full time administrator; and

(e) provides an ongoing quality assurance program.

Hospice Agency means a public or private agency or organization which administers and provides Hospice Care Services or operates a Hospice.

Hospice Care Facility means a facility providing Hospice Care Services which is appropriately licensed or certified as such under the law of the jurisdiction in which it is located, and which:

(a) is certified (or is qualified and could be certified) under Medicare;

(b) is accredited by the Joint Commission on the Accreditation of Healthcare Organizations; or

(c) meets the standards established by the National Hospice Organization.

Hospice Care Plan means a coordinated, interdisciplinary program to meet the physical, psychological and social needs of Terminally Ill Covered Persons and their families:

(a) by providing palliative (pain controlling) and supportive medical, nursing and other health services; and

(b) through home, Hospice, Hospice Care Facility or inpatient Hospital care during the Sickness or bereavement.

Hospice Care Services means any services provided:

(a) under a Hospice Care Plan; and

(b) by a Hospital, Hospice Agency, Hospice Care Facility or other facility licensed by the proper authority in the jurisdiction to operate the Hospice.

Immediate Family means the Covered Person's:

(a) spouse and children; or

(b) parents, brothers and sisters, in the case of a Terminally Ill dependent child.

Respite Care means a short-term inpatient stay which is necessary for the Covered Person in order to give temporary relief to a Caregiver who regularly assists the Covered Person with home health care. Inpatient Respite Care is limited each time to a stay of no more than five days in a row.

Terminally Ill means a Covered Person is:

(a) determined by a Physician to have a terminal Sickness with no reasonable prospect of cure; and

(b) expected by a Physician to have less than six months to live.

Exceptions (applicable to Home Health Care Services and/or Hospice Care Services)

The Plan will not pay benefits for:

(a) services and supplies which are not part of a Home Health Care Plan or Hospice Care Plan;

(b) services of a Caregiver or other person who lives in Your home or is a member of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse);

(c) domestic or housekeeping services that are unrelated to the Covered Person's care;

(d) services that provide a protective environment when no skilled service is required (such as companionship or sitter services); or

(e) services which are not directly related to the Covered Person's medical condition, including, but not limited to:
   (1) estate planning, drafting of wills or other legal services;
   (2) pastoral counseling or funeral arrangements or services;
   (3) nutritional guidance or food services such as "meals on wheels"; or
   (4) transportation services.

8. **Covered Spinal Treatment (nonsurgical) Services**

If You or Your dependent incurs Expense for nonsurgical Spinal Treatment by a Physician, the Plan will pay benefits up to the **Maximum Spinal Treatment (nonsurgical) Benefit** shown in the **Schedule**.

Spinal Treatment means nonsurgical manipulation for a condition of the spinal column to relieve the effects of nerve interference which results from or relates to any such condition of the vertebral spinal column.

9. **Covered Qualified Organ(s)/Tissue Transplant Services**

If You or Your dependent incurs Expense for a Qualified Organ(s)/Tissue Transplant, the Plan will pay benefits for the following:

(a) **Recipient:** Expense incurred by a Recipient up to the **Maximum Recipient Benefit** shown in the **Schedule** for:
   (1) the use of temporary mechanical equipment, pending the acquisition of "matched" organ(s)/tissue;
   (2) multiple transplants during one operative session;
   (3) replacement(s) or subsequent transplant(s); and
   (4) follow-up Expense for items (1) through (3) above (including immunosuppressive therapy).

(b) **Donor:** Expense incurred by a Donor(s) up to the **Maximum Donor Benefit** shown in the **Schedule** for:
   (1) testing to identify suitable Donor(s);
   (2) acquisition of organ(s)/tissue from a Donor;
   (3) life support of a Donor pending the removal of a usable organ(s)/tissue;
   (4) transportation for a living Donor; and
   (5) transportation of organ(s)/tissue or a Donor on life support.

   Benefits under item (b) are payable only when the Recipient is a Covered Person.

(c) **Medical Specialty Network Option (MSN)**: Additional benefits for Covered Services provided by the MSN are shown in the **Schedule**.

Conditions

United must be notified of the transplant at least seven days before the scheduled transplant date, or as soon as reasonably possible prior to the transplant date for any of the following:

(a) the evaluation of the Recipient; and

(b) testing to identify suitable Donors.

Definitions (applicable to Covered Qualified Organ(s)/Tissue Transplant Services)

Donor means a person who undergoes a surgical operation for the purpose of donating a organ(s)/tissue for Transplant Surgery to a Recipient.

Qualified Organ(s)/Tissue Transplants means transplants for any of the following:

(a) cornea;

(b) heart;

(c) lung;

(d) heart/lung;

(e) liver;

(f) kidney;

(g) pancreas;

(h) kidney/liver;

(i) intestinal;

(j) intestinal/liver;

(k) kidney/pancreas; and

(l) bone marrow/peripheral stem cell transplants; or

(m) any other organ(s)/tissue transplant that is Medically Necessary.

Recipient means a Covered Person who undergoes a surgical operation to receive an organ(s)/tissue transplant.

Transplant Surgery means transfer of an organ(s)/tissue from the Donor to the Recipient.

Exceptions (applicable to Covered Qualified Organ(s)/Tissue Transplant Services)

The Plan will not pay benefits for:

(a) any Expense for Transplant Surgery when approved alternative remedies are available

(b) any mechanical organ(s) except as provided under Section 9. Covered Qualified Organ/Tissue Transplant Services, item (a) (1) above; or

(c) any financial consideration to the Donor other than benefits for Expense which is necessary in the performance of or relation to Transplant Surgery.

10. **Covered Routine Health Care Services**

If You or Your dependent receives routine health care services, including but not limited to, routine physical examinations, laboratory tests, x-rays, immunizations and screenings for a family history of a condition performed in:

(a) a Hospital outpatient department; or

(b) a Physician's office or clinic;

the Plan will pay benefits for the Expense incurred for such health care service, but not to exceed the **Maximum Routine Benefit** shown in the **Schedule**.

Exception (Applicable to Covered Routine Health Care Services)

The Plan will not pay benefits for:

(a) routine health care services performed during a Hospital Confinement; or

(b) routine health care services for procedures classified as surgical including, but not limited to, colonoscopies and sigmoidoscopies.

11. **Covered Routine Mammography Services**

If, a Covered Person who is age 35 or over incurs Expense for Routine Mammography, the Plan will pay the **Maximum Routine Mammography Benefit** as shown in the **Schedule**, but not to exceed one mammogram each Calendar Year.

Definition

Routine Mammography means a routine x-ray examination of the breast.

12. **Covered Preventive Health Care Services**

(For Dependent Children Through the Age Limit Shown in the Schedule)

If Your dependent child receives preventive health care services (other than Childhood Immunization Services), including but not limited to, routine physical examinations, laboratory tests, x-rays, and immunizations in:

(a) a Hospital outpatient department; or

(b) a Physician's office or clinic;

The Plan will pay benefits for the Expense incurred for such services, but not to exceed the **Maximum Preventive Benefit** shown in the **Schedule**.

Exception (applicable to Preventive Health Care Services Benefits)

The Plan will not pay benefits for preventive health care services performed during a Hospital Confinement.

13. **Covered Childhood Immunization Services**

(For Dependent Children Through the Age Limit Shown in the Schedule)

If Your dependent child receives Childhood Immunization Services, the Plan will pay benefits for the Expense incurred for such services, but not to exceed the **Maximum Immunization Benefit** shown in the **Schedule**.

Definition

Childhood Immunization Services means the complete set of vaccinations for children as recommended by the American Academy of Pediatrics or the Advisory Committee on Immunization Practices. The vaccinations include (but are not limited to) immunizations against measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, haemophilus influenzae type b and hepatitis-B.

14. **Contraceptives Benefits**

Definition

Contraceptive Drugs and/or Devices means drugs or devices that prevent unwanted pregnancy including, but not limited to:

(a) oral contraceptives;

(b) IUD's;

(c) contraceptive implants; or

(d) any similar drug, device or method.

Benefits

If a Covered Person receives Contraceptive Drugs and/or Devices, including any services associated with the use of such drug or device, the Plan will pay the Expense incurred in the same manner and subject to the same conditions and limitations as any other Covered Service.

Conditions

The Contraceptive Drug and/or Device:

(a) requires a Physician's written prescription; and

(b) must be approved by the United States Food and Drug Administration for use as a contraceptive.

Exception

Any exclusion for birth control drugs or Devices will not apply.

15. **Colorectal Cancer Screening Benefits**

If a Covered Person undergoes a colonoscopy or sigmoidoscopy, the Plan will pay the Expense incurred in the same manner and subject to the same conditions and limitations as any other Covered Service.

16. **48-Hour Maternity Benefits**

Benefits

If, while covered under this provision, You or Your dependent are confined to a Hospital as a resident inpatient for childbirth, the Plan will pay benefits in the same manner and subject to the same conditions and limitations as any other Sickness, but, in no event, will benefits be provided for less than:

(a) 48 hours following a vaginal delivery; or

(b) 96 hours following a cesarean section;

for the mother and the newborn infant(s), unless the attending Physician, in consultation with the mother, recommends an earlier discharge.

In the event such earlier discharge occurs, a follow-up visit by a registered nurse will be available to the mother, and payable in the same manner and subject to the same conditions and limitations as any other Covered Service.

17. **Mental And Nervous Disorders Benefits**

Definitions

For purposes of this provision, the following terms have the following meanings:

Inpatient Treatment means Covered Services provided by a Physician for treatment of a Mental and Nervous Disorder during Hospital Confinement and while under 24-hour Physician supervision.

Outpatient Treatment means any Covered Service for treatment of a Mental and Nervous Disorder of less than 24-consecutive-hours, regardless of how it is classified.

Mental and Nervous Disorders Benefits

If You or Your dependent, while covered under this provision, is treated for a Mental and Nervous Disorder, the Plan will pay benefits as follows:

(a) up to the **Maximum Inpatient Benefit** shown in the **Schedule** for Expense incurred for Inpatient Treatment; or

(b) up to the **Maximum Outpatient Benefit** shown in the **Schedule** for Expense incurred for Outpatient Treatment based on a written plan approved and supervised by a Physician.

Exceptions

The Plan will not pay Mental and Nervous Disorder benefits for:

(a) the following conditions, diagnoses or therapies:
  (1) conduct disturbances unless related to a coexisting condition or diagnosis for which benefits are payable;
  (2) educational, vocational and/or recreational services;
  (3) biofeedback for treatment of diagnosed medical conditions;
  (4) treatment for learning disabilities;
  (5) pervasive developmental disorders (other than diagnostic evaluation), including but not limited, to:
    a. autistic disorders;
    b. Rett's Disorder; and
    c. Asperger's Disorder;

(b) treatment which United of Omaha determines to be for the Covered Person's personal growth or enrichment; or

(c) court ordered placements when such placements are not determined to be Medically Necessary.

18. **Chemical Dependency Benefits**:

If You or Your dependent, while covered under this provision, is treated for chemical dependency, the Plan will pay as follows.

Inpatient Benefits

If You or Your dependent enters a hospital or a treatment facility as a resident patient, the Plan will pay the expense incurred for the following:

(a) room and board; and

(b) services and supplies, including services performed during detoxification treatment;

in the same manner as for any other sickness.

Outpatient Benefits

If You or Your dependent enters a hospital or a treatment facility for outpatient treatment, the Plan will pay the expense incurred in the same manner as for any other sickness.

Definitions

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

Controlled Substance means a toxic inhalant or a substance designated as a controlled substance as defined by Texas law.

Toxic Inhalant means a volatile chemical, or abusable glue or aerosol paint as defined by Texas law.

Outpatient Treatment means individual or group therapy or any other covered service provided in a covered alcohol or drug dependency facility or physician's office on an outpatient basis.

Treatment Facility means a facility which has a program for inpatient or outpatient treatment of chemical dependency based on a written plan approved and supervised by a physician or qualified credentialed counselor; and which:

(a) is affiliated with a hospital which has an established patient referral system;

(b) is accredited as a chemical dependency facility by the Joint Commission on the Accreditation of Hospitals;

(c) has a chemical dependency treatment program licensed by the proper authority of the state in which it is located; or

(d) has a chemical dependency treatment program licensed, certified or approved by any other state agency with legal authority to do so.

19. **Partial Hospitalization Benefits**

Definition

For the purposes of this provision, the following term has the following meaning:

Partial Hospitalization means a Hospital stay:

(a) for a child (a person under age 13) or adolescent (a person age 13 but under age 18): for a minimum of four hours per day or 16 hours over a seven consecutive day period; or

(b) for an adult (a person age 18 or over): for a total of at least 20 hours over a five consecutive day period.

Benefits

If, while covered under this provision, You or Your dependent incurs Expense for Partial Hospitalization as a result of a Mental and Nervous Disorder or Chemical Dependency, the Plan will pay benefits for Partial Hospitalization, as follows:

(a) benefits payable are subject to the same limitations and conditions as for Hospital Confinement for Mental and Nervous Disorder and Chemical Dependency treatment; and

(b) two days of Partial Hospitalization for which benefits are payable will be considered as one day of Hospital Confinement.

Partial Hospitalization must be a Medically Necessary alternative to Hospital Confinement.

20. **Routine Vision Care Benefits**

If You or Your dependent, while covered under this provision, incurs Expense for **Covered Vision Exam Services** shown in the **Schedule,** the Plan will pay the lesser of:

(a) the Expense incurred; or

(b) the amount shown in the **Schedule**.

Exceptions

The Plan will not pay for:

(a) any of the following services and supplies:
  (1) visual field charting;
  (2) orthoptics or vision training;
  (3) contact lenses;
  (4) subnormal vision aids;
  (5) aniseikonic lenses;
  (6) tinted lenses; or
  (7) nonprescription lenses;

(b) medical or surgical treatment of the eyes;

(c) services and supplies which are payable under a workers' compensation or occupational disease law;

(d) any Expense which results from an act of declared or undeclared war or armed aggression;

(e) any Expense which is in excess of the Usual and Customary Charges;

(f) any Expense which You or Your dependent does not have to pay;

(g) any eye examination required as a condition of employment;

(h) more than one exam for any Covered Person during any one Calendar Year; or

(i) any Expense paid in whole or in part by any other provision of the Group Health Plan provided by Us.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

This replaces any outpatient or out-of-Hospital prescription drug benefit provision that covers prescription medicines obtained through:

(a) retail pharmacies;

(b) mail-order pharmacies; or

(c) other pharmacies;

but not obtained through the following facilities while the Covered Person is confined in a:

(a) Hospital;

(b) skilled nursing care facility or convalescent home;

(c) rest home or nursing home; or

(d) sanitarium or treatment facility.

PAYMENT FOR A PRESCRIPTION DRUG DOES NOT CONSTITUTE ANY ASSUMPTION OF LIABILITY FOR SICKNESS, INJURY, OR CONDITION UNDER THE PLAN OR BOOKLET.

OUTPATIENT PRESCRIPTION DRUG BENEFITS
For You and Your Dependents

Benefits

After the Prescription Drug Copayment is satisfied, the Plan will pay the remaining Expense incurred for a Covered Drug for up to a:

(a) 30-day supply from a Retail Pharmacy; or

(b) 90-day supply from a Participating Prescription-by-Mail (Mail Order) Pharmacy.

The Prescription Drug Copayment is shown in the Schedule.

With the prescribing Physician's approval, United of Omaha may, at their discretion, substitute:

(a) one (1) Brand Name Drug for another Brand Name Drug; or

(b) one (1) Therapeutically Equivalent Drug for another Therapeutically Equivalent Drug.

Certain drugs, which may include some Compound Drugs, require prior authorization by United to be covered, or may be subject to clinical quantity limits.

United may use other clinical management programs to ensure appropriate medication utilization.

Prescription refills will be covered when no more than 25% of the days' supply, based on the Physician's written order, remains.

If the Covered Person is purchasing more than a 30-day supply from a Retail Pharmacy or a 90-day supply from a Participating Prescription-by-Mail (Mail Order) Pharmacy, any Expense exceeding the 30-day or 90-day supply limit will not be covered by the Plan.

For a Participating Retail Pharmacy

A prescription obtained with a valid identification card **will not** require that You submit the Prescription Drug Program Claim Form.

If a valid identification card is not used, the Covered Person pays the total Expense at the pharmacy. To be eligible for reimbursement by the Plan, the Covered Person must submit the Prescription Drug Program Claim Form as described in the Payment of Claims provision below.

For a Non-Participating Retail Pharmacy

The Covered Person pays the total Expense at the pharmacy. To be eligible for reimbursement by the Plan, the Covered Person must submit the Prescription Drug Program Claim Form as described in the Payment of Claims provision below.

For a Participating Prescription-by-Mail (Mail Order) Pharmacy

For medications which You are taking on a regular basis, the Physician may order more than a 30-day supply of such medication, but not more than a 90-day supply.

If the Physician is prescribing Maintenance Drugs, have the Physician write two (2) prescriptions:

(a) the first for Your immediate needs (30 days or less); and

(b) the second for You to submit to the Participating Prescription-By-Mail (Mail Order) Pharmacy.

Payment of Claims

If there is no FDA-approved, chemically-equivalent Generic Drug, the Plan will pay the total Expense for the Brand Name Drug after the Prescription Drug Copayment is satisfied.

For a Participating Retail Pharmacy

You must present Your ID card to the Participating Pharmacy when receiving services. You do not need to file a claim form when You use the services of a Participating Pharmacy.

If a valid identification card is not used, the Covered Person pays the total Expense and must complete the Prescription Drug Program Claim Form. The instructions are shown on the form.

For a Non-Participating Retail Pharmacy

The Covered Person pays the total Expense and must complete the Prescription Drug Program Claim Form. The instructions are shown on the form.

For a Participating Prescription-By-Mail (Mail Order) Pharmacy

Complete the Registration Form the first time You order under this program. This form is not required after Your first order.

Complete the Prescription Order Form, attach Your Physician's written prescription and include the appropriate Copayment for each prescription or refill.

If an insufficient amount is included for the Copayment, the Covered Person will be responsible for any additional amount due.

Forms needed for refills and future prescription orders will be provided each time You receive a supply of medication from this program.

For **refill prescriptions**, You may also call customer service to order refills by phone. The phone number is shown on the form returned to You when You originally ordered the prescription. You will need the prescription number and a credit card for payment when calling.

Specialty Pharmacy Drugs and Medicines

When Your Physician prescribes one of the drugs or medicines which are required to be purchased through a Specialty Pharmacy, and You purchase the medication through a retail or mail order pharmacy, You will be notified that the particular drug You are purchasing is required to be purchased through one of United's Specialty Pharmacies in order to receive the participating provider benefit. After written notification, You will be able to complete one refill through the retail pharmacy before Your benefit will be reduced to the non-participating provider benefit. For a list of Specialty Drugs please call the customer service Number on Your ID card or go to United's website at www.mutualofomaha.com.

Exception

Benefits for Emergency Care at a non-Specialty Pharmacy will be paid in the same manner as if the service was provided by a Specialty Pharmacy.

Coordination of Benefits (COB)

If a Covered Person is covered by another plan or plans, the Plan will not coordinate benefits between this Plan and any other plan under this provision.

Definitions

Brand Name Drugs means proprietary Covered Drugs approved by the FDA.

Copayment means an amount which the Covered Person must pay before benefits are payable and which is incurred on the date the Covered Drug is received. A Copayment can be a dollar amount, a percentage amount, or a combination of a dollar amount and a percentage. Copayments may not be used to satisfy any Deductible or any Out-of-Pocket Expense shown in any other provision of the Plan.

Compound Drug means a drug that has been prepared, mixed, assembled, packaged or labeled at a pharmacy pursuant to a Physician's prescription. Compound drugs are made from raw chemicals and powders. In order to be considered for benefits under this Prescription Drug Benefits provision, at least one (1) Prescription Drug must be included in the final preparation of the compound drug.

Covered Drugs means either of the following which require a Physician's written prescription:

(a) drugs and medicines which are needed for the treatment of an Injury or Sickness, including insulin and certain Diabetic Supplies; or

(b) contraceptives. (Any exclusion shown elsewhere in this Booklet for contraceptives will not apply.)

Diabetic Supply or **Diabetic Supplies** include needles, syringes, test tablets, sticks, tapes, strips, lancets and alcohol swabs.

Drug Formulary means United's current listing of Covered Drugs preferred by United for dispensing to a Covered Person when appropriate. This list is subject to periodic review and modification.

In the event a Generic Drug becomes available as a brand formulary drug, the generic equivalent automatically becomes the formulary drug and the brand formulary drug then becomes non-formulary.

You are not restricted to the listed medications under the Drug Formulary. United encourages You to discuss Your medication needs with Your Physician. Your Physician may be contacted to discuss Your prescriptions that are included on the Drug Formulary as well as those that are not included on the Drug Formulary.

Emergency Care means covered pharmacy services a Covered Person receives:

(a) to treat an accidental Injury or emergency medical condition which requires immediate care; and

(b) under circumstances or at locations which reasonably prevent the Covered Person from obtaining services of a Specialty Pharmacy.

Generic Drugs mean Covered Drugs which are chemically equivalent to Brand Name Drugs whose patent has expired and which are approved by the FDA. Not all Brand Name Drugs have a generic equivalent.

Maintenance Drugs mean Covered Drugs which are prescribed for a chronic condition requiring continued medication on a regular or long-term basis.

Medically Necessary, as used in this provision, means prescription drug products which are:

(a) determined to be medically appropriate;

(b) dispensed pursuant to a prescription order or refill;

(c) necessary to meet the basic health needs of Covered Persons; and

(d) consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies.

The fact that a prescribing Physician prescribes a Covered Drug or the fact that it may be the only treatment for a particular Injury or Sickness does not mean that it is medically necessary.

Non-Participating Pharmacy means a pharmacy which is not a Participating Pharmacy.

Nonprescription Drug means medicines or drugs which may be sold without a prescription and which are prepackaged for use by the consumer and labeled in accordance with the requirements of the laws and regulations of state and federal government. All over-the-counter drugs are nonprescription drugs.

Participating Pharmacy means a pharmacy which:

(a) has been contracted to provide prescription drug products to Covered Persons; and

(b) is shown in United's current directory.

United will publish an updated list of Participating Pharmacies periodically. For the latest list of Participating Pharmacies, contact the Plan Administrator, or go to United's website at www.mutualofomaha.com.

United does not supervise, control or guarantee the services of any Participating Pharmacy or Non-Participating Pharmacy.

Prescription Drug, Device, or Legend Drug or Device means:

(a) a drug or device which is required under federal law to be labeled with one (1) of the following statements prior to being dispensed or delivered:
   (1) Caution: Federal law prohibits dispensing without a prescription; or
   (2) RX only; or

(b) a drug or device which is required by an applicable federal or state law to be dispensed pursuant only to a prescription or chart order or which is restricted to use by Physicians only.

Specialty Pharmacy means a Participating Pharmacy which provides specified drugs. Specialty Pharmacies and a list of specialty medications are shown on United's website at www.mutualofomaha.com or You may call 1-800-467-4917 to receive more information regarding Specialty Pharmacies.

Therapeutically Equivalent Drug means a drug product which contains a different chemical entity, but provides similar treatment effects or pharmacological action.

Exceptions

The Plan will not pay for:

(a) drugs (in whole or in part) obtained through the following facilities while the Covered Person is confined in a:
   (1) Hospital;
   (2) skilled nursing care facility or convalescent home;
   (3) rest home or nursing home; or
   (4) sanitarium or treatment facility;

(b) prescription refills in excess of the number specified by the Physician;

(c) drugs or medicines dispensed more than one (1) year after the date of the prescription;

(d) more than a 30-day supply from a Retail Pharmacy or a 90-day supply from a Participating Prescription-by-Mail (Mail Order) Pharmacy for any drugs or medicines which are dispensed in a quantity which (when taken as the Physician directs) exceeds a 30-day or 90-day supply;

(e) drugs that have no FDA-approved indications for use;

(f) FDA-approved drugs or dosage regimens used for indications or routes of administration outside FDA-approval, subject to United's Investigational Drug use policy;

(g) Prescription drugs with a therapeutically equivalent over-the-counter agent; including, but not limited to dietary supplements, formula, herbal and homeopathic medications;

(h) drugs or medicines used for cosmetic purposes or beauty aids;

(i) drugs or medicines that have been determined under the internal standards of the FDA to be "less-than-effective" in accordance with the Drug Efficacy Study Implementation (DESI) or where the same prescription drug item, or an equivalent, is also available over-the-counter (OTC) or can lawfully be obtained without a Physician's prescription;

(j) Expense for which benefits are paid under any other provision of the Plan;

(k) new Prescription Drugs which offer no therapeutic or clinically significant advantage to other Prescription Drugs within the same therapeutic class, and are available on a more cost effective basis;

(l) Compound Drugs that offer no therapeutic or clinically significant advantage over any commercially available product; or

(m) anything excluded under the General Exclusions and Limitations.

PREEXISTING CONDITIONS

These Preexisting Conditions will apply if a Covered Person:

(a) becomes covered under the Plan after its effective date;

(b) becomes covered under the Plan on its effective date and was not covered under the prior group health plan on the day before this Plan became effective; or

(c) becomes covered under the Plan on its effective date and was covered under the prior group health plan for a period of less than 365 days.

Preexisting Conditions Provision

If a Covered Person received treatment or service for an injury or sickness in the 90 day period before that person was covered under the Plan, the Plan:

(a) will not pay benefits of more than $500 for that injury, sickness or any related condition until the earlier of:
  (1) the day after a 90 day period has passed from the time that person was covered and during which no treatment or service was received for that injury, sickness or related condition; or
  (2) the day after a 365 day period has passed from the time that person was covered; and

(b) will pay only for loss or expense incurred after such 90 day or 365 day period. Payment will be in accord with the provisions of the Plan.

Effect Of A Preexisting Condition

If a Covered person becomes covered under the Plan on its effective date and was covered under the prior group health plan for a period less than 365 days:

1. Benefits will be paid in accordance with the provisions of the Plan if the Covered Person satisfies the preexisting conditions provisions under:

   (a) this Plan; or

   (b) the prior group health plan, giving consideration towards continuous time covered or the period during which no treatment or service was received under both plans.

2. If the Covered Person cannot satisfy the preexisting conditions provision of this policy nor that of a prior group health plan, benefits payable under this Plan will be limited to $500.

3. If there was no preexisting conditions provision under the prior group health plan, then there will be no preexisting conditions provision applied under this group plan.

All related conditions shall be considered to be one injury or sickness.

Definition

Prior group health plan means the group health plan (whether insured or self-insured including HMO's and other prepayment plans provided by Us) in effect immediately prior to the effective date of this Plan.

DEFINITIONS

Terms defined in this provision are used in, or apply to other provisions throughout the Plan or any Plan Changes. Definitions of other terms may be found in other provisions.

Unless otherwise defined in the Plan or any Plan Changes, the following terms have the following meanings. Any singular word shall include any plural of the same word.

Acupuncture means the practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia or for therapeutic purposes.

Allowable Charge means the maximum amount otherwise payable under the Plan for services and supplies by Professional Service Providers, adjusted as follows:

(a) **Charges of Professional Service Providers for Multiple and Bilateral Surgeries.** For multiple or bilateral surgeries performed during the same operative session, the allowable charge for charges of Professional Service Providers will be:
   (1) 100% of the Usual and Customary Charge for the primary procedure; and
   (2) 50% of the Usual and Customary Charge for each additional procedure.

Procedures considered incidental to the surgical procedures are not covered.

(b) **Surgical Assistance.** For surgical assistance by a Physician, the allowable charge will be 20% of the Usual and Customary Charge for the surgery for which the assistance is provided.

(c) **Covered Services Billed Separately or Together.** United will determine whether it is appropriate for services and supplies to be billed together as a single service or supply, or billed separately. For example, United may determine that the evaluation, treatment, management and supplies normally furnished before, during or after surgical and medical procedures should be billed together. Or, United may determine that services or supplies that were billed together should be billed separately. The allowable charge will not exceed the amount payable in accordance with United's determination of which services or supplies should appropriately be billed separately or together.

Booklet means the self-funded Plan coverage form and all other documents that describe coverage under the Plan and are made a part of the Plan.

Cosmetic Surgery or Service means any surgical procedure or service performed primarily:

(a) to improve physical appearance without materially correcting a bodily malfunction; or

(b) to prevent or treat a Mental and Nervous Disorder through a change in bodily form.

Covered Person means You and /or each of Your dependents who are covered under the Plan.

Covered Service means any service or supply described in this Booklet for which benefits may be payable in accordance with the terms of the Plan.

Custodial Care means services or supplies, regardless of where or by whom they are provided, which:

(a) a person without medical skills or background could provide or could be trained to provide;

(b) are provided primarily to help the Covered Person with daily living activities, including but not limited to:
   (1) walking, getting in and/or out of bed, exercising and moving the Covered Person;
   (2) bathing, using the toilet, administering enemas, dressing and assisting with any other physical or oral hygiene needs;
   (3) assistance with eating by utensil, tube or gastrostomy;
   (4) homemaking, such as preparation of meals or special diets, and housekeeping;
   (5) acting as a companion or sitter; or
   (6) supervising the administration of medications which can usually be self-administered, including reminders of when to take such medications;

(c) primarily provide a protective environment;

(d) are primarily part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve the Covered Person's Sickness, Injury or functional ability;

(e) primarily are provided for the convenience or comfort of the Covered Person or the Covered Person's companion, family member or sitter; or

(f) are provided because the Covered Person's home arrangements are not appropriate or adequate to accommodate his or her needs.

United, or a qualified party or entity selected by United, determine what services or supplies are custodial care. When a Hospital Confinement, a visit to a Physician or other service or supply is found to be primarily for custodial care, some services or supplies (such as prescription drugs, x-rays and lab tests) may still be considered Covered Services if they are Medically Necessary and benefits are otherwise payable for such services or supplies in accordance with the Plan.

Dentist means a person who:

(a) is appropriately licensed and qualified to practice dentistry under the law of the jurisdiction in which the dental procedure is performed; and

(b) is operating within the scope of his/her license.

A dentist does not include You, a person who lives with You or is a member of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse).

Developmental Care means services or supplies, regardless of where or by whom they are provided which:

(a) are provided to a Covered Person who has not previously reached the level of development expected for the Covered Person's age in the following areas of major life activity:
   (1) intellectual;
   (2) physical;
   (3) receptive and expressive language;
   (4) learning;
   (5) mobility;
   (6) self-direction;
   (7) capacity for independent living; or
   (8) economic self-sufficiency;

(b) are not primarily rehabilitative (restoring skills that were lost or impaired due to Injury or Sickness); or

(c) are primarily educational.

United, or a qualified party or entity selected by United determines what services or supplies are developmental care. When a Hospital Confinement, a visit to a Physician or other service or supply is found to be primarily for developmental care, some services or supplies (such as prescription drugs, x-rays and lab tests) may still be considered Covered Services if they are Medically Necessary and benefits are otherwise payable for such services or supplies in accordance with the Plan.

Expense means the charge incurred by a Covered Person for a Covered Service which has been ordered, prescribed or rendered by a Dentist, Physician or Hospital. Expense is considered incurred on the date the Covered Service is received. Expense does not include any charge:

(a) for a service or supply otherwise excluded under the Plan;

(b) which is in excess of the charge which the Dentist, Physician or Hospital has agreed to accept as payment in full;

(c) for a service or supply which is not Medically Necessary; or

(d) which is in excess of the Usual and Customary Charge, the Facility Charge Allowance or the Allowable Charge for a service or supply.

Experimental or Investigational Drug or Treatment means a drug, device, treatment or procedure:

(a) which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which has not been so approved for marketing at the time the drug, device, treatment or procedure is furnished;

(b) which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure which is used with a patient informed consent document which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function;

(c) which Reliable Evidence shows is the subject of on-going phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(d) for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence means only published reports and articles in peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure; or the patient informed consent document used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure.

Facility Charge Allowance means the maximum amount payable under the Plan for certain Facility charges related to inpatient and outpatient services at an Out-of-Network Provider, as determined as follows:

(a) **Charges for Inpatient Services**. The facility charge allowance for services provided by a Facility who is an Out-of-Network Provider, which exceed a minimum dollar amount of $1500 and are associated with any inpatient stay at a Facility in which confinement is more than 24 hours, will be limited to the amount calculated by using the Facility Charges Database. In no event will the facility charge allowance exceed the amount billed to United or the amount for which the Covered Person is responsible.

(b) **Charges for Outpatient Services.** The facility charge allowance for services provided by a Facility who is an Out-of-Network Provider, which exceed a minimum dollar amount of $250 and are associated with any outpatient service at a Facility in which confinement is less than 24 hours, will be limited to the lesser of:

(1) the 75th percentile identified by the Outpatient Charges Database; or
(2) the amount calculated by using the Facility Charges Database.

In no event will the facility charge allowance exceed the amount billed to United or the amount for which the Covered Person is responsible.

For multiple or bilateral outpatient surgeries performed during the same operative session, the facility charge allowance will be further adjusted as follows:

(1) 100% of the facility charge allowance for the highest cost procedure;
(2) 25% of the facility charge allowance for the second highest cost procedure; and
(3) 10% of the facility charge allowance for each additional procedure.

The Covered Person may be responsible for amounts that exceed the facility charge allowance. If the facility charge allowance is less than the amount charged by the Out-of-Network Provider, or less than the amount the Covered Person is responsible for, the Covered Person may be responsible for the difference. If the Covered Person is asked to pay this difference by the Out-of-Network Provider, and if requested, United will attempt to reduce the amount the Covered Person may owe to the Out-of-Network Provider. If United's attempts are unsuccessful, the Covered Person may still be responsible for the difference.

Facility or Facilities mean, for purposes of determining the Facility Charge Allowance and for use in the Facility Charges Database and Outpatient Charges Database definitions, a Hospital, Hospice Care Facility, Skilled Nursing Facility, or any other free standing facility.

Facility Charges Database means a commercially available database and software program selected by United that provides information about the inpatient and outpatient costs and charges for Facilities. The database supplier uses the cost accounting method for Facilities established and used by Medicare as the basis to calculate cost to charge ratios for various inpatient and outpatient services provided by Facilities. Those ratios are then used as the basis for the formula to calculate the Facility Charge Allowance for certain services provided by Out-of-Network Providers that are Facilities. Expenses may not exceed the Facility Charge Allowance charge as determined in accordance with the facility charges database. The facility charges database will be updated by the database supplier, up to twice each year. United may discontinue use of, or substitute or replace the database with one of comparable purpose, with or without notice.

Outpatient Charges Database means commercially available charge information databases selected by United which use charge information databases that provide historical information about charges billed by Facilities on an outpatient basis by selected procedure codes and geographic categories, all as determined and adjusted by the database supplier. The outpatient charges database will be updated by the database supplier, up to twice each year. United may discontinue use of, or substitute or replace any database with one of comparable purpose, with or without notice.

Healthcare Charges Database means a commercially available charge information database selected by United that provides historical information about the charges of Physicians and other Professional Service Providers by procedure code and geographic categories, all as determined and adjusted by the database supplier. The healthcare charges database will be updated by United as information becomes available from the database supplier, up to twice each year. United may also modify the database in United's discretion to reflect United's experience. United has the right, in United's discretion, to substitute or replace the selected database with a database or databases of comparable purpose, with or without notice.

Hospital means any of the following facilities that are licensed by the proper authority in the jurisdiction in which they are located:

(a) a facility which:
  (1) provides inpatient services for the care and treatment of patients;
  (2) has a registered graduate nurse (RN) always on duty;
  (3) has a laboratory and x-ray facility;
  (4) as a regular practice, charges patients for its services; and
  (5) has a resident Physician on duty or call at all times;

(b) a facility which is accredited by the Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities, if the function of such facility is primarily to provide rehabilitation specifically for treatment of a physical disability. Rehabilitative facilities need not have major surgical facilities; or

(c) a facility or a birthing center which is equipped and operated solely to provide prenatal care; to perform uncomplicated, spontaneous deliveries; and to provide immediate post-partum care. Such facility must either be licensed by the state as indicated above or must satisfy all or of the following:
  (1) be directed by at least one (1) Physician specializing in obstetrics or gynecology;
  (2) have a Physician or nurse midwife present during each birth;
  (3) provide skilled nursing services in the delivery and recovery rooms (under the direction of an RN or nurse midwife);
  (4) have at least two (2) birthing rooms or beds, diagnostic x-ray and lab equipment (or a contract to use that of an area medical facility), and emergency equipment;
  (5) admit only patients with low-risk pregnancies (and contract with an area Hospital for transfer of emergency cases); and
  (6) regularly charge patients for services and supplies.

When treatment is needed for a Mental and Nervous Disorder/Alcohol and Drug Abuse and/or Substance Abuse, hospital can also mean a facility which is licensed by the proper authority of the jurisdiction in which it is located and:

(a) provides inpatient services for the care and treatment of patients;

(b) is equipped to treat Mental and Nervous Disorders/Alcohol and Drug Abuse and/or Substance Abuse;

(c) has a resident Physician on duty or on call at all times;

(d) has a registered graduate nurse (RN) always on duty; and

(e) as a regular practice, charges patients for its services.

A hospital does not include a facility or institution, or units within a facility or institution, which is licensed or used principally as a clinic, convalescent home, rest home, nursing home, home for the aged, halfway house, board and care facility, residential treatment center, “wilderness” program, treatment group home or “boot camp."

Hospital Confinement means a Medically Necessary Hospital inpatient stay of 24-consecutive-hours or more in any single or multiple departments or parts of a Hospital for the purpose of receiving any type of medical service. These requirements apply even if the Hospital does not charge for daily room and board or does not classify the confinement as an inpatient stay.

Injury means an accidental bodily injury which is the direct result of a sudden, unexpected and unintended external force or element, such as a blow or fall that requires treatment by a Physician. It must be independent of Sickness or any other cause, including, but not limited to, complications from medical care.

Jaw Joint Disorder means any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint). It includes temporomandibular joint dysfunction (TMJ), arthritis or arthrosis, other craniomandibular joint disorders, and myofacial or orofacial pain syndrome. It does not include a fracture or dislocation which results from an Injury, any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint).

Medical Emergency means a medical condition or behavioral condition of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(a) placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) serious impairment to bodily functions;

(c) serious disfigurement of the Covered Person;

(d) serious impairment of any bodily organ or part of the Covered Person; or

(e) in the case of a behavioral condition, placing the health of the Covered Person or other persons in serious jeopardy.

Medically Necessary means a service or supply that is ordered, prescribed or rendered by a Physician or Hospital and is determined by United, or a qualified party or entity selected by United, to be:

(a) provided for the diagnosis or direct treatment of an Injury or Sickness;

(b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Covered Person's Injury or Sickness;

(c) provided in accordance with generally accepted professional standards and/or medical practice; and

(d) the most appropriate supply or level of service which can be provided on a cost effective basis (including, but not limited to, inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care.)

Services or supplies which may be medically necessary are not covered by the Plan if they are specifically excluded or limited in the General Exclusions and Limitations provision.

The fact that the Covered Person's Physician or a Hospital orders, prescribes or renders services or supplies does not automatically mean such services or supplies are medically necessary and a Covered Service.

Mental and Nervous Disorder/Alcohol and Drug Abuse and/or Substance Abuse means any disease, disorder or condition, regardless of its cause, physical or chemical origin, symptoms, diagnostic findings or features, or method of treatment, that is listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association, and any disease, disorder or condition added in any supplemental or subsequent edition of the Manual.

A mental and nervous disorder/alcohol and drug abuse and/or substance abuse includes, but is not limited to, any disease, disorder or condition of the following major diagnostic categories and their respective subgroups:

(a) Mental Disorders Due to General Medical Conditions (e.g. Delirium, Sleep Disorder);

(b) Substance-Induced Disorders (e.g. Substance-related disorders, substance-induced psychotic disorder, substance withdrawal, substance intoxication);

(c) Psychotic Disorders (e.g. Schizophrenia, Schizoaffective Disorder);

(d) Mood Disorders (e.g. Bipolar Disorder, Major Depressive Disorder);

(e) Anxiety Disorders (e.g. Panic Disorder, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder); or

(f) Somatoform Disorders (e.g. Sexual Dysfunction, Hypochondriasis).

Certain mental and nervous disorder/alcohol and drug abuse and/or substance abuse disorders and therapies are excluded from coverage as specifically described in the Plan.

Our, We, or Us means Cameron County.

Out-of-Network Provider or Other Provider means a provider of Covered Services who is not currently participating in the Preferred Provider network.

Physician means any of the following practitioners who is appropriately licensed and qualified under the law of the jurisdiction in which treatment is rendered and operating within the scope of his/her license:

(a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);

(b) behavioral health care practitioner (such as social workers, psychologists, etc.);

(c) physician's assistant (PA);

(d) a nurse practitioner; or

(e) any other provider as required by applicable law.

A physician does not include You, a person who lives with You or is part of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse).

Professional Service Provider means any category of Physician or other health care provider that typically bills on the basis of the CPT or HCPCS code system(s).

Reconstructive Surgery means any surgical procedure which repairs an abnormal body structure.

Plan means Cameron County group medical plan.

Plan Change means a document that is added to and made a part of the Plan. A plan change amends, limits, restricts or otherwise changes the provisions of the Plan.

Sickness means a disease, disorder or condition which requires treatment by a Physician.

1. For a female employee/member or dependent wife, Sickness **includes** childbirth or pregnancy. It **does not include** Elective Abortion; but it **does include** complications which are the result of an Elective Abortion.

2. For a dependent child, Sickness **does not include** Normal Pregnancy or Normal Childbirth, but it **does include** Complications of Pregnancy.

   Elective Abortion means any abortion other than one where the mother's life would be endangered if the fetus were carried to term.

   Normal Pregnancy or **Normal Childbirth** means pregnancy or childbirth which is free of Complications of Pregnancy.

   Complications of Pregnancy means:

   (a) any condition resulting in Hospital Confinement, the diagnosis of which is distinct from pregnancy but is adversely affected or caused by pregnancy; or

   (b) a nonelective cesarean section, an ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, a puerperal infection, eclampsia and toxemia.

   False labor, occasional spotting, Physician prescribed rest, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy are not Complications of Pregnancy.

Total Disability, Totally Disabled or Disabled means that because of an Injury or Sickness:

(a) You are completely and continuously unable to perform the material and substantial duties of Your regular occupation and are not engaging in any work or occupation for wages or profit; or

(b) Your dependent is:
   (1) either physically or mentally unable to perform all of the usual and customary duties and the normal activities and duties of a person of the same age and sex who is in good health; and
   (2) not engaged in any work or occupation for wages or profit.

United/United of Omaha means United of Omaha Life Insurance Company.

Usual and Customary Charge means a charge by a Professional Service Provider who is an Out-of-Network Provider or Other Provider for a Covered Service which is no higher than the 90th percentile identified on the Healthcare Charges Database (HCD). When there is, in United's determination, minimal data available from the HCD for a Covered Service, United will determine the usual and customary charge by calculating the unit cost for the applicable service category using HCD, and multiplying that by the relative value of the Covered Service assigned by the Medicare Resource Based Relative Value Scale (supplemented with a commercially available relative value scale selected by United where one is not available from Medicare). In the event of an unusually complex Covered Service, a Covered Service that is a new procedure or a Covered Service that otherwise does not have a relative value that is in United's determination applicable, United will assign one. In no event will the usual and customary charge exceed the amount billed by the Professional Service Provider or the amount for which the Covered Person is responsible. The term "usual and customary charge" may not reflect the actual charges of the Professional Service Provider, and does not take into account the Professional Service Provider's training, experience or category of licensure.

You or Your means an employee or member who is covered under the Plan.

UTILIZATION MANAGEMENT PROVISIONS

UTILIZATION REVIEW

Utilization Review Procedures are only intended to determine if health care services or supplies are Medically Necessary under the terms of the Plan.

Before the services or supplies are received, all Hospital Confinements, Outpatient Surgical Procedures and Specialized Services and Supplies identified in these provisions must be pre-certified by United as Medically Necessary. **You, not Your Physician, are responsible for making sure a pre-certification determination has been made**. However, You, Your representative or Your Physician may initiate the pre-certification.

Pre-certification of a proposed service or supply as Medically Necessary through the Utilization Review process does not necessarily mean that benefits are payable. Confirmation of a person's eligibility for Plan coverage for a particular service or supply, and fulfillment of all other Plan requirements, are also necessary for benefits to be payable.

Definitions

Care Review Unit means United's Care Review Unit staff or a qualified party or entity named by them. For the toll-free phone number, refer to Your identification card or contact Your Plan Administrator.

Outpatient Mental and Nervous Disorders or Chemical Dependency means any individual, group, family or intensive outpatient therapy for the treatment of a Mental and Nervous Disorder or Chemical Dependency, regardless of how it is classified.

Outpatient High End Radiology means nuclear radiology tests listed below which are performed:

(a) in a Physician's office or clinic;

(b) on an outpatient basis in a Hospital (excluding those performed in a Hospital Emergency Room); or

(c) in an Independent Radiology and Pathology Center.

Outpatient high end radiology includes:

(a) magnetic resonance imaging (MRIs);

(b) magnetic resonance angiogram (MRAs);

(c) computerized tomography scan (CT Scans);

(d) positron emission tomography scan (PET Scans); and

(e) single photon emission computed tomography scan (SPECT Scans).

Outpatient Surgical Procedures means the outpatient surgical procedures listed below which are performed:

(a) in an ambulatory surgical facility;

(b) in a Physician's office or clinic; or

(c) on an outpatient basis in a Hospital.

Outpatient surgical procedures include:

(a) carpal tunnel release - surgery to relieve a pinched nerve in the hand;

(b) cochlear implants - insertion of small computer device to transmit to the auditory nerve;

(c) endometrial ablations - complete removal of the lining of the uterus;

(d) hysterectomy - surgical removal of the uterus;

(e) pelvic laparoscopy - examination of the female organs by a scope;

(f) tonsillectomy with/without adenoidectomy - surgical removal of the tonsil and adenoids;

(g) septoplasty - surgical procedure to straighten the nasal septum; and

(h) UPP (uvulopalatopharyngoplasty) or laparoscope aided UPP - removal of a portion of the uvula and soft palate.

Specialty Drugs and Medicines means the injectable specialty drugs or medicines for the ongoing treatment of a chronic condition which are given:

(a) in a Physician's office or clinic; or

(b) in a home health care setting.

Specialty Drugs and Medicines includes, but is not limited to, those used for the following:

(a) asthma;

(b) inflammatory bowel disease;

(c) growth hormone deficiency;

(d) neurologic disease;

(e) osteoporosis;

(f) psoriasis;

(g) rheumatoid arthritis;

(h) immune deficiency; or

(i) injectable drugs or medications with uses for indications excluded under the Plan.

Specialized Services and Supplies means the services or supplies listed below:

(a) home health care;

(b) outpatient hospice care;

(c) durable medical equipment: the purchase or rental of any single piece of durable medical equipment with a purchase price of $1,000 or more; and

(d) prosthetics.

Pre-certification Requirements

You must pre-certify with United the following:

1. Hospital Confinement, Skilled Nursing Facility confinement and inpatient Hospice Care Facility due to a Sickness or Injury;
2. Hospital Confinement and partial hospitalization for Mental and Nervous Disorders or Chemical Dependency;
3. Outpatient Mental and Nervous Disorders or Chemical Dependency Therapy;
4. Specialty Drugs and Medicines;
5. Outpatient High End Radiology;
6. Outpatient Surgical Procedures; and
7. Specialized Services and Supplies.

You, Your representative or Your Physician must request pre-certification from the Care Review Unit. The Care Review Unit will advise You and Your Physician of the review decision.

United recommends pre-certification be initiated at least seven (7) days before the Hospital Confinement, Outpatient Surgical Procedure, Outpatient Mental and Nervous Disorders or Chemical Dependency Therapy or Specialized Services and Supplies begin or are received. If not pre-certified at least one (1) business day prior, a penalty will apply.

Within two (2) business days, or as soon as reasonably possible for a Medical Emergency, You, Your representative or Your Physician must notify the Care Review Unit of the Hospital Confinement, the Outpatient Surgical Procedures and/or the Specialized Services or Supplies. If not pre-certified within this time frame, a penalty will apply. The Care Review Unit will advise You and Your Physician of the review decision.

If a visit to a Hospital Emergency room exceeds 24 hours, any additional observation in the emergency room must be pre-certified. This is applicable even if the visit does not result in a Hospital Confinement.

Effect on Benefits

The following penalties will apply if services are not properly pre-certified by United.

1. For Hospital Confinement due to a Sickness or Injury, Skilled Nursing Facility, inpatient Hospice Care Facility, Hospital Confinement and Partial Hospitalization for Mental and Nervous Disorders or Chemical Dependency:

   Prior to admission, if a Covered Person does not first initiate the required pre-certification and it is determined that the Hospital Confinement and related Covered Services were:

   (a) Medically Necessary, benefits payable for the room and board will be reduced by $500; or

   (b) not Medically Necessary, no benefits are payable.

During the confinement, if a Covered Person has received pre-certification for a specified number of days and wants to stay for additional days, the additional days must be approved by United as described in the Pre-certification Requirement section. If the additional days are not pre-certified by United and subsequent review determines the days were;

(a) Medically Necessary, benefits payable for the room and board will be reduced by $500; or

(b) not Medically Necessary, no benefits will be payable.

Note: For Services that could have been provided on an outpatient basis, but are performed in an inpatient/Hospital Confinement setting when Hospital Confinement was determined to not be Medically Necessary, the room and board will not be payable. Expenses for other Covered Services provided during the Hospital Confinement (including but not limited to x-ray and laboratory services) will be considered in accordance with applicable Plan provisions.

2. For Outpatient Surgical Procedures, Outpatient Mental and Nervous Disorder/Chemical Dependency, Specialized Services or Supplies, Outpatient High End Radiology or Non-Retail Specialty Drugs and Medicines:

   Prior to treatment, if a Covered Person does not first obtain the required pre-certification and it is determined that the Covered Services were:

   (a) Medically Necessary, benefits payable will be reduced by $500; or

   (b) not Medically Necessary, no benefits are payable.

   During the treatment, if a Covered Person has received pre-certification for a specified number of days/visits/treatments and wants additional days/visits/treatments, the additional days/visits/treatments must be approved by United as described in the Pre-certification Requirement section. If the additional days/visits/treatments are not pre-certified by United and subsequent review determines the days/visits/treatments were:

   (a) Medically Necessary, benefits payable will be reduced by $500 per days/visits/treatments; or

   (b) not Medically Necessary, no benefits will be payable.

When benefits are reduced in accordance with this Effect on Benefits section, the reduction will not be used to satisfy any deductible or out-of-pocket limit shown in the Schedule.

Exceptions

1. Pre-certification is **not** required when the Covered Person has Medicare coverage which:

   (a) has primary responsibility for the Covered Person's claim; and

   (b) must pay its full benefits before Plan benefits are paid in accordance with the Medicare Coordination of Benefits provision of the Plan.

2. Pre-certification is **not** required for the initial 48-hour inpatient Hospital Confinement for a vaginal delivery or the 96-hour inpatient Hospital Confinement for a Cesarean section delivery.

3. Pre-certification is **not** required for services or supplies performed or provided, outside the United States, Mexico and Canada or any state, district, province, territory or possession thereof.

Request for an Appeal of United's Utilization Review Decision

You, Your representative or Your provider of health care have the right to request an appeal regarding United's Utilization Review decisions. The request should be submitted in writing and should include any additional information that may have been omitted from United's review or that should be considered by United. Requests should be sent to:

Mutual of Omaha
Medical Management
Appeals and Grievance
PO Box 31640
Omaha, NE 68131-0640

You may also call the toll-free phone number listed on Your identification card for additional information regarding United's appeal process.

CASE MANAGEMENT PROGRAM

The Case Management Program is a voluntary program intended to provide assistance to Covered Persons with certain Injuries or Sicknesses. If a Covered Person participates in the Case Management Program, United will coordinate with the Covered Person, family members and health care providers in the development of a health care treatment plan that is intended to:

(a) respond to the Covered Person's health care needs; and

(b) be cost-effective and promote efficient use of Plan benefits.

The proposed health care treatment plan must be approved by United to ensure that any care provided pursuant to the plan is Medically Necessary, cost-effective and involves efficient use of Plan benefits. The health care treatment plan is also subject to approval by the Covered Person and his or her Physician.

The Case Management Program may be initiated by:

(a) the Covered Person;

(b) the Covered Person's family members;

(c) the Covered Person's Physician; or

(d) United.

It is the Covered Person's decision whether or not to participate in United's Case Management Program.

The Case Management Program does not replace the care received from the Covered Person's Physician. The Covered Person and his or her Physician remain in charge of the Covered Person's health care treatment plan.

Effect on Benefits

Benefits payable for services or supplies provided in accordance with the Case Management Program shall be at least equal to benefits otherwise payable under the Plan. Any such benefits will be subject to the Maximum shown in the Schedule.

The Case Management Program may recommend medically appropriate alternatives to the traditional or proposed care that has been identified for You. United may propose an exchange of other benefits as a less costly alternative benefit. This may include extending benefits that have been exhausted or substituting one benefit for another.

Conditions

Alternative benefits will be made available only for a limited time period and are subject to ongoing review. You must cooperate with the review process in order to receive the alternative benefit and You must agree to the alternative benefit in writing. By approving the alternative benefit, United cannot guarantee You will receive that alterative benefit in the future. The decision to offer an alternative benefit is solely United's, and except as expressly provided in writing, United may withdraw it at any time and resume regular contract benefits. United's decision to offer or withdraw alternative benefits is not subject to Appeal under the disputed claims process.

GENERAL EXCLUSIONS AND LIMITATIONS

Exclusions and limitations listed in this provision apply to provisions throughout the Plan and any Plan changes. Exclusions and limitations that are used in other provisions may be found in those provisions.

Unless otherwise payable under the Plan or any Plan Changes, the following exclusions and limitations shall apply.

NOTE: Services and supplies which may be Medically Necessary are not covered by the Plan if they are specifically excluded or limited in this General Exclusions and Limitations provision.

The Plan does not pay benefits under the Plan for any Expense or loss:

(a) for an Injury or Sickness:
  (1) which arises out of, or in the course of, any employment with any employer subject to any workers' compensation law; and
  (2) for which the Covered Person:
    a. is entitled to benefits under any workers' compensation or occupational disease law, employer's liability or similar laws, regardless of whether the employer is in compliance with that law;
    b. was not compensated under any such laws as a result of the Covered Person's failure to comply with requirements relating to notice of injury, timely filings of claims, and medical treatment authorizations; or
    c. receives any settlement from a worker's compensation carrier;

(b) which is in excess of the Usual and Customary Charge, the Facility Charge Allowance or the Allowable Charge;

(c) for services or supplies that are not Medically Necessary;

(d) any treatment, service or supply unless it is shown under Covered Services of the Major Medical Benefits;

(e) incurred after coverage ends;

(f) which is not the result of an Injury or Sickness;

(g) for an Injury or Sickness that occurred while committing a felony or participating in a riot;

(h) incurred by a Covered Person while incarcerated in a jail, penitentiary, correctional facility or Hospital while incarcerated;

(i) which the Covered Person does not have to pay;

(j) for Custodial Care, except as part of a Home Health Care Plan approved by United;

(k) for Developmental Care;

(l) which results from Reconstructive Surgery, except:
  (1) for an Injury;
  (2) for repair of defects which result from surgery; or
  (3) for the reconstructive (not cosmetic) repair of a congenital defect which materially corrects a bodily malfunction;

(m) which results from Cosmetic Surgery or Service;

(n) which relates to appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria, and presents significant symptomatic medical problems) or any treatment of obesity (including surgery to treat morbid obesity), unless otherwise specifically provided in the Plan;

(o) for routine foot care, orthopedic shoes, foot orthotics or other supportive devices for the feet;

(p) in connection with dental work, or dental surgery (unless otherwise specifically provided in the Plan) including:
  (1) treatment or replacement of any tooth or tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue; or
  (2) surgery or splinting to adjust dental occlusion;

(q) for treatment of Jaw Joint Disorders (unless otherwise specifically provided in the Plan);

(r) related to sexual and gender identity disorders, including but not limited to:
  (1) sexual dysfunctions;
  (2) paraphilias; or
  (3) gender transformations;

(s) for services or supplies for the treatment of impotence or erectile dysfunction;

(t) for the diagnosis or treatment of the inability to conceive or become pregnant, or the promotion of fertility, including, but not limited to:
  (1) fertility tests and procedures;
  (2) reversal of surgical sterilization; or
  (3) any similar method or treatment which attempts to cause conception or pregnancy by hormone therapy, artificial insemination, in vitro fertilization and/or embryo transfer, unless otherwise specifically provided in the Plan;

(u) for chelation therapy, except for acute arsenic, gold, mercury or lead poisoning;

(v) for services or supplies which are not provided in accordance with generally accepted professional standards and/or medical practice;

(w) for services or supplies which:
  (1) are considered an Experimental or Investigational Drug or Treatment; or
  (2) result from or relate to the application of an Experimental or Investigational Drug or Treatment;

(x) for services or supplies which are primarily for the Covered Person's education, training or development of skills needed to cope with an Injury or Sickness, unless otherwise specifically provided in the Plan;

(y) related to smoking cessation or treatment for nicotine addiction, unless otherwise specifically provided in the Plan;

(z) for Acupuncture treatment (except when used in lieu of an anesthetic agent for surgery);

(aa) which is primarily for the Covered Person's convenience or comfort or that of the Covered Person's family, caregiver, companion, sitter, Physician or other person;

(ab) for bills for telephone calls, mailings, faxes, e-mails, online evaluations or any other communications to or from a Physician, Hospital or other medical provider, except as required by state or federal law;

(ac) which results from breast augmentation or reduction, whether or not Medically Necessary, except for breast reconstruction following a mastectomy as required under state or federal law/regulation;

(ad) which results from:
(1) pervasive developmental disorders;
(2) mental retardation; or
(3) developmental disorders;

(ae) for educational testing or educational remediation;

(af) for therapies designed to promote personal growth or enhancement absent a diagnosis of a Mental and Nervous Disorder/Chemical Dependency;

(ag) for exercise equipment;

(ah) routine eye refractions, unless otherwise specifically provided in the Plan;

(ai) the fitting or cost of visual aids, eyeglasses, vision therapy, radial keratotomy or similar surgery done for the correction of any refraction error or astigmatism, except for corneal graft;

(aj) the fitting or cost of hearing aids and related supplies;

(ak) services provided by a person who lives with You in Your home or is a member of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse);

(al) non-surgical Spinal Treatment, except as specifically provided in the Plan;

(am) Chemical Dependency, except as specifically provided in the Plan;

(an) Mental and Nervous Disorders, except as specifically provided in the Plan;

(ao) body organ(s)/tissue transplants, except as specifically provided in the Plan;

(ap) for services or supplies which are provided or paid for by the federal government or its agencies, except for:
(1) the Veterans Administration, when services are provided to a veteran for a disability which is not service-connected;
(2) a military Hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services;
(3) a group health plan established by a government or its agencies for its own civilian employees and their dependents; or
(4) Medicaid, if required by a Medicaid assignment of benefits;

(aq) which results from an act of declared or undeclared war or armed aggression; or

(ar) which:
(1) is incurred while the Covered Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; and
(2) for which any governmental body or its agencies are liable.

COORDINATION OF BENEFITS (COB)

Definitions

Plan means a form of coverage with which coordination is allowed. Separate parts of a Plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one Plan and there is no Coordination of Benefits among the separate parts of the Plan.

Plan includes:

(a) group and non-group coverage contracts and subscriber contracts;

(b) Health Maintenance Organization (HMO) contracts;

(c) group and non-group coverage through Closed Panel Plans;

(d) Group-type Contracts;

(e) the medical care components of long-term care contracts, such as skilled nursing care;

(f) the medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts; and

(g) Medicare or other federal governmental plan, as permitted by law, excluding a state plan under Medicaid.

Plan does not include:

(a) hospital indemnity coverage benefits or other fixed indemnity coverage;

(b) accident only coverage;

(c) specified disease or specified accident coverage;

(d) limited benefit health coverage;

(e) school accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;

(f) benefits provided in long-term care policies for non-medical services such as personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(g) Medicare supplement policies;

(h) a state plan under Medicaid; or

(i) a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

Claim means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

(a) services, including supplies;

(b) payment for all or a portion of the expenses incurred;

(c) a combination of services and payment for expenses incurred; or

(d) an indemnification

Claimant means the Covered Person for whom the Claim is made.

Closed Panel Plan means a plan that provides health benefits to a Claimant primarily in the form of services through panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Consolidated Omnibus Budget Reconciliation Act of 1985 or **COBRA** means coverage provided under a right of continuation pursuant to federal law.

Coordination of Benefits (COB) means a provision establishing an order in which plans pay their Claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

A **Covered Expense** means any health care expense, including deductibles, coinsurance or co-payments, that is covered at least in part by any of the Plans covering the Claimant. Where a Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of each service will be considered a Covered Expense. An expense that is not covered by any Plan covering the Claimant is not a Covered Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not a Covered Expense.

A **Covered Expense** is not:

(a) The difference in cost of a private hospital room and the cost of a semiprivate room, unless the Claimant's stay in a private room is medically necessary.

(b) Any amount in excess of the highest reimbursement methodology, when the Claimant is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, relative value schedule reimbursement, or similar reimbursement methodology.

(c) An amount in excess of the highest of the negotiated fees, when the Claimant is covered by two or more Plans that provide benefits or services on the basis of negotiated fees.

(d) Any expense which is not payable by the Primary Plan because of the Claimant's failure to comply with the Plan provisions is not a Covered Expense. Examples of these types of Plan provisions include second surgical opinions, pre-certification of admissions, and preferred provider arrangements.

If a Plan is advised by a Claimant that all Plans covering the Claimant are high-deductible health plans and the Claimant intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health Plan's deductible is not a Covered Expense, except for any health care expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the

Primary Plan's payment arrangement will be the Covered Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Covered Expense used by the Secondary Plan to determine its benefits.

Custodial Parent means the parent awarded custody of a child by a court decree or, in absence of a court decree, the parent with whom the child reside more than one half of the calendar year without regard to any temporary visitation.

Group-type Contract means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. It does not include individually underwritten and issued guaranteed renewable policies even if the plan is purchased through payroll deduction at a premium savings to the Covered Person since the Covered Person would have the right to maintain or renew the plan independently of continued employment with the employer.

Primary Plan means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A Plan is a Primary Plan if:

(a) the Plan either has no order of benefit determination rules, or its rules differ from those permitted by state law and regulation; or

(b) all plans that cover the person use the order of benefit determination rules required by state law and regulation, and under those rules the plan determines its benefits first.

Secondary Plan means a Plan that is not a Primary Plan.

Coordination of Benefits (COB)

If the Claimant is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan (which is the Plan that pays benefits first) pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

2. Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage is excess to any other parts of the plan provided by Us. Examples of this situation are major medical coverage that is superimposed over base plan hospital and surgical benefits, or other type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

3. Except as provided in provision 2 above, a Plan that does not contain Order of Benefit Determination provisions consistent with state law or regulation is always the Primary Plan, unless the provisions of all Plans state that the complying Plan is primary.

4. A Plan may take into consideration the benefits paid or provided by another Plan, only when under the Order of Benefit Determination rules below, it is secondary to that Plan.

This COB provision will not apply to a claim when the Covered Expense is $50 or less.

Order of Benefit Determination

Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent:

   (a) If a Plan that covers the Claimant other than as a dependent, for example as an employee, member, Plan Administrator, subscriber, or retiree is the Primary Plan and the Plan that covers the Claimant as a dependent is the Secondary Plan.

   (b) However, if the Claimant is a Medicare beneficiary and, as a result of Title XVIII of the Social Security Act and implementing regulations, Medicare is secondary to the Plan covering the Claimant as a dependent; and primary to the Plan covering the Claimant as other than a dependent; then the order of benefits is reversed so that:
      (1) the Plan covering the Claimant as a dependent pays first;
      (2) Medicare will pay second; and then
      (3) the Plan covering the Claimant as an employee, retiree, member, subscriber, or nondependent will pay.

2. Dependent Child Covered Under More Than One Plan: Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

   (a) If the Claimant is a dependent child whose parents are married, living together, or share joint custody by court decree, whether or not they have ever been married:
      (1) the Plan of the parent whose birthday anniversary is earlier in the calendar year is Primary;
      (2) if both parents have the same birthday, the Plan that has covered the parent the longest is Primary; or
      (3) if another Plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that Plan's COB rule will determine the order of benefits;

   (b) If the Claimant is a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married (except when sharing joint custody), then the following rules apply:
      (1) if a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule does not apply to benefits paid before the Plan has actual knowledge of the court decree;
      (2) if a court decree states the one parent is responsible for their dependent child's health care expenses or coverage and that parent does not have health care coverage for the child's health care expenses, but that parent's spouse does, that parent's spouse's Plan is Primary. This rule does not apply to benefits paid before the Plan has actual knowledge of the court decree;
      (3) if a court decree states that:
         a. both parents are responsible for the dependent child's health care expenses or coverage; or

b. provides joint custody without specifying who is responsible for the dependent child's health care expenses or coverage;

then the provisions used in paragraph (b) above will determine the order of benefits; or

(4) if there is no court decree which requires a parent to provide health coverage to a dependent child, or when the Plan covering the parent has no knowledge of the court decree, then the order of benefits for the child are as follows:
   a. the Plan covering the Custodial Parent;
   b. the Plan covering the Custodial Parent's spouse;
   c. the Plan covering the non-Custodial Parent; and then
   d. the Plan covering the non-Custodial Parent's spouse.

(c) If a dependent child is covered under more than one Plan of individuals who are not the parents of the child, the order of benefits will be determined as provided by paragraph (b) above, or as if those individuals were parents of the child.

3. Active Employee or Retired or Laid-off Employee:

(a) If the Plan covers the Claimant as:
   (1) an active employee; that is, as an employee who is neither laid-off or retired employee; or
   (2) a dependent of an active employee;

   then it is the Primary Plan.

(b) If the Plan covers the Claimant as:
   (1) a retired or laid-off employee; or
   (2) a dependent of a retired or laid-off employee;

   then it is the Secondary Plan.

(c) If the other Plan does not have this laid off or retired employee rule, and if, as a result the Plans do not agree on the order of benefits, this rule will not apply. This rule also does not apply if the Non-Dependent or Dependent rule can determine benefits.

4. COBRA or State Continuation Coverage:

(a) if a Claimant whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to federal or state law is also covered under another Plan:
   (1) the Plan covering the Claimant as an employee, member, subscriber or retiree (or a dependent of such an employee) is the Primary Plan; and
   (2) the Plan under which the Claimant's continuation coverage is provided is the Secondary Plan.

(b) If the other Plan does not have this rule regarding continued coverage, and if as a result, the Plans do not agree on the order of benefits this rule will not apply.

5. Length of Coverage: If none of the above rules apply, the Plan which has covered the Claimant for the longer period of time will pay its benefits first.

6. If none of the preceding rules determines the order of benefits, the Covered Expenses will be shared equally between Plans.

How COB Affects Plan Benefit Limits

1. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan year are not more than the total Covered Expenses. In determining benefits as a Secondary Plan, United will calculate the benefits United would have paid as a Primary Plan and apply that amount towards any Covered Expense not paid by the Primary Plan. The Secondary Plan may then reduce its payment so that when combined with the amount paid by the Primary Plan, the total benefits paid for provided by all Plans for a Claim does not exceed the total Covered Expense for that Claim. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
2. If a Claimant is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right To Collect and Release Needed Information

In order to receive benefits, the Claimant must give United any information which is needed to coordinate benefits. United may release to or collect from any person or organization with legitimate interest in the Claim or any needed information about the Claimant.

Facility of Payment

If benefits which this Plan should have paid are instead paid by another Plan, this Plan may reimburse the other Plan. Amounts reimbursed are plan benefits and are treated like other plan benefits in satisfying plan liability.

Right of Recovery

If the amount of payments made by this Plan pays more for a Covered Expense than is required by this provision, the excess payment may be recovered from:

(a) the Claimant;

(b) any person to whom the payment was made; or

(c) any insurance company, service Plan or any other organization which should have made payment.

The amount of payments made includes the reasonable cash value of any benefits provided in the form of services.

MEDICARE COORDINATION OF BENEFITS

Medicare COB

This Medicare COB provision applies when the Covered Person:

(a) has health coverage under the Plan; and

(b) is eligible for coverage under Medicare, Parts A and B, whether or not the Covered Person has applied or is enrolled in Medicare Part B; and/or

(c) is enrolled in Medicare Part D.

It applies before any other COB provision of the Plan.

Effect on Benefits

1. If, in accord with the following rules, the Plan has primary responsibility for the Covered Person's claims, then United pays Plan benefits first.
2. If, in accord with the following rules, the Plan has secondary responsibility for the Covered Person's claims:

   (a) first Medicare Benefits are determined or paid; and

   (b) then Plan benefits are paid;

   but, for services payable under both plans, the combined Medicare Benefits and Plan benefits will not exceed 100% of the Expense incurred.

Rules for Determining Order of Benefits

1. **For You.** The Plan has primary responsibility for Your claims if:

   (a) You are covered under the Plan because of Your current active employment status with an ADEA employer, and You are eligible for Medicare benefits because of age; or

   (b) the Plan is part of a large group plan, and You are covered under the Plan because of Your current active employment status, and You are eligible for Medicare benefits because of disability.

   The Plan has secondary responsibility for Your claims if You are eligible for Medicare benefits and the above conditions do not apply.

2. **For Your Dependent.** The Plan has primary responsibility for Your dependent's claims if:

   (a) You are covered under the Plan because of Your current active employment status with an ADEA employer, and Your dependent spouse is eligible for Medicare because of age; or

   (b) the Plan is part of a large group plan, and You are covered under the Plan because of Your current active employment status, and Your dependent is eligible for Medicare benefits because of disability.

The Plan has secondary responsibility for Your dependent's claims if Your dependent is eligible for Medicare benefits and the above conditions do not apply.

3. **Exception for End Stage Renal Disease.** If Medicare does not already have primary responsibility when You or Your dependent becomes eligible for Medicare benefits because of end stage renal disease:

   (a) the Plan has primary responsibility for Your or Your dependent's claims for up to 30 months beginning with the month in which You or Your dependent is first eligible for Medicare benefits because of end stage renal disease; and

   (b) the Plan has secondary responsibility after the end of this 30-month period.

Definitions

Medicare Benefits means service and supplies which the Covered Person receives or is eligible for under Medicare Part A or B, whether or not the Covered Person has applied for or is enrolled in Medicare Part B or prescription drugs received under Medicare Part D.

ADEA Employer means an employer which:

(a) is subject to the federal Age Discrimination in Employment Act (ADEA); and

(b) has 20 or more employees each working day in 20 or more calendar Weeks during the current or preceding calendar year.

Large Group Plan means a plan which covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.

Important Information About Medicare

Medicare may affect Plan benefits; therefore, You may want to contact Your local Social Security office for information about Medicare. This should be done before Your or Your spouse's 65th birthday.

THIRD PARTY REIMBURSEMENT AND/OR SUBROGATION

This provision applies if You or Your dependent is injured or sick as a result of the act or omission of a Third Party.

Definitions

For the purposes of this provision, the following terms have the following meanings:

Reimbursement Rights means the Plan's right to be reimbursed if:

(a) The Plan pays benefits for You or Your dependent because of an Injury or Sickness caused by a Third Party's act or omission; and

(b) You, Your dependent or the legal representative recovers an amount from the Third Party, the Third Party's insurer, an uninsured motorist insurer or anyone else by reason of the Third Party's act or omission. This recovery may be the result of a lawsuit, a settlement or some other act. The Plan is entitled to be paid out of any recovery, up to the amount of benefits the Plan pays.

Subrogation Rights, as used in this provision, means the Plan's right to enforce recovery of any Plan benefits paid for You or Your dependent because of an Injury or Sickness caused by a Third Party's act or omission. The Plan is entitled to be paid out of any recovery, up to the amount of benefits the Plan pays.

Third Party means another person or organization.

Reimbursement Rights and Subrogation Rights

If You or Your dependent has an Injury or Sickness caused by a Third Party's act or omission:

1. The Plan will pay benefits for that Injury or Sickness subject to the Plan's Reimbursement Rights and Subrogation Rights and on condition that You or Your dependent (or the legal representative of You or Your dependent):

   (a) will not take any action which would prejudice the Plan's Reimbursement Rights or Subrogation Rights; and

   (b) will cooperate in doing what is reasonably necessary to assist Us in enforcing the Plan's Reimbursement Rights or Subrogation Rights.

2. The Plan's Reimbursement or Subrogation Rights will not be reduced because the recovery is not described as being related to medical costs or loss of income.

3. The Plan may enforce Reimbursement Rights or Subrogation Rights by filing a lien with the Third Party, the Third Party's insurer or another insurer, a court having jurisdiction in this matter or any other appropriate party.

4. The amount of the Plan's Reimbursement will not be reduced by legal fees or court costs incurred in seeking the recovery, unless the Plan agrees otherwise in writing.

COBRA GROUP HEALTH COVERAGE CONTINUATION

(As Federally Mandated)

Definitions

Health Coverage as used in this provision generally means the hospital, surgical, medical, dental, vision, or prescription drug coverage You had on the day before the qualifying event. Health coverage is subject to change as a result of open enrollments or Plan modifications. Unless dental and/or vision coverage is provided through a separate plan, a Covered Person cannot continue only dental and/or vision coverage.

Conversion Coverage means individual or family hospital, surgical and medical coverage issued without evidence of good health.

NOTE: Conversion Coverage does not provide the same benefits You or Your dependent has while covered under the Plan. Consequently, expenses covered under the Plan may not be covered by the Conversion Coverage or may be covered at a different level. You may contact the Plan Administrator or us at any time for a description of the conversion benefits then available. Conversion Benefits are subject to change.

Continuation of Group Health Coverage

1. **For You and Your Dependents.** You and/or any covered dependent may elect to continue Health Coverage for as long as 18 months from the day Your coverage ends because of these qualifying events:

   (a) Your employment terminates (other than due to gross misconduct); or

   (b) You no longer satisfy the requirements for hours worked.

   If a Covered Person is determined, in accordance with Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continued coverage, the reference to 18 months in the preceding sentence is deemed a reference to 29 months. Notice of such determination must be given to the Plan Administrator before the first 18 months of continued coverage ends and within 60 days of the date of the determination. Refer to Part 3 of this provision.

   During the period You continue coverage:

   (a) any new eligible dependents You acquire may be added in accord with the Dependents Eligibility provisions; and

   (b) any eligible dependents You declined to cover before Your continued Health Coverage began may be added during any open enrollment period provided by the Plan;

   provided any additional premium is paid. However, such dependents, other than a qualified beneficiary, who are added after the qualifying event will not be entitled to continue coverage as qualified beneficiaries after an event occurs as shown in part 2.

Qualified beneficiary means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the Plan:

(a) as the spouse of the covered employee; or

(b) as the dependent child of the employee.

Qualified Beneficiary also includes a child who is born or is placed for adoption with the covered employee during the period of continued coverage.

2. **For Your Dependents Only.** Your covered spouse and/or each of Your covered dependent children may elect to continue Health Coverage for as long as 36 months from the day coverage ends because of these qualifying events:

   (a) You die;

   (b) You become entitled to Medicare benefits;

   (c) You and Your spouse are legally separated;

   (d) Your marriage is ended by divorce; or

   (e) a child is no longer an eligible dependent.

   If Your dependent is already continuing coverage under part 1 when an event shown in part 2 occurs, that second event will not entitle Your dependent to continue coverage beyond 36 months under parts 1 and 2 combined.

   If Your dependent becomes entitled to continue Health Coverage under both parts 1 and 2 on the same day, the periods of continued coverage will run concurrently and will not exceed 36 months.

3. **Notice Requirements.** We are required by law to notify the Plan Administrator within 30 days after Your termination of employment, reduction in hours, death or entitlement to Medicare. You must notify the Plan Administrator within 60 days after the day You are legally separated or divorced, or Your child ceases to be an eligible dependent.

   If a Covered Person is determined, in accordance with Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continued coverage, that person must:

   (a) notify the Plan Administrator within 60 days of the date of the determination and before the first 18 months of continued coverage ends; and

   (b) notify the Plan Administrator within 30 days of the date of any final determination that he or she is no longer disabled. Then, continued coverage ends the month that begins more than 30 days after the date of such final determination.

   Within 14 days after receiving notice of a qualifying event, the Plan Administrator will send You or Your dependent written notice of the continuation right. The Plan Administrator must receive Your or Your dependent's written request to continue Health Coverage within 60 days after the day:

   (a) Health Coverage ends; or

   (b) the Covered Person is sent notice of the continuation right;

   whichever is later.

To continue coverage, You or Your dependent must pay the required premium, including any retroactive premium. The initial premium must be paid to the Plan Administrator within 45 days after the day continued coverage is elected. The Plan Administrator will inform You or Your dependent of procedures to pay subsequent monthly premiums.

4. **End of Continuation**. A Covered Person's continued Health Coverage will end at midnight on the earliest of:

   (a) the day We cease to provide any group health Plan to any employee;

   (b) the day premium is due and unpaid;

   (c) the day a Covered Person is covered under group coverage as an employee or otherwise. However this does not apply when the Covered Person is covered under another group plan which contains any preexisting condition limitations which apply to that person. Then, he or she may continue coverage under this Plan until the earlier of:
      (1) the day the preexisting conditions limitation under the new group plan no longer applies; or
      (2) the day continued coverage would otherwise end;

   (d) the day a Covered Person again becomes covered under the Plan;

   (e) the day a Covered Person is entitled to benefits under Medicare;

   (f) the day Health Coverage has been continued for the period of time provided in Part 1, Part 2 or the first item (b) of Part 3 above (or any longer period provided in the Plan);

   (g) the day the Plan terminates.

5. **Other Continuation Provisions.** In the event Health Coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or in part by Us, then the premium You are required to pay may increase for the remainder of the 18-month, 29-month, or 36-month period provided above.

6. **Conversion Coverage.** Arrangements have been made with United of Omaha Life Insurance Company to make available a hospital and surgical coverage conversion plan without medical examination when coverage under this plan ends. You have 31 days after Your coverage ends to make application and pay the required premium or Your individual or family plan. The conversion plan shall become effective on the date the application is made or on the date the coverage ends, whichever is later. If available under the plan, conversion coverage may only be obtained when continued Health Coverage ends because of the expiration of the 18-month, 29-month or 36-month period provided above.

PAYMENT OF CLAIMS

How to File Claims

Before benefits are paid, United of Omaha or the Claims Administrator must be given a written proof of loss, as described below. In the event of Your death or incapacity, Your beneficiary or someone else may give us the proof.

Proof of Loss Requirements (for Preferred Providers)

You do not need to file a claim form when You use the services of a Preferred Provider. Just present Your ID card to the Preferred Provider when receiving services.

Proof of Loss Requirements (for Other Providers)

1. First, request a claim form from the Plan Administrator or from the Claims Administrator.

   This request should be made:

   (a) within 20 days after a loss occurs; or

   (b) as soon as reasonably possible.

   When Your request is received You will be sent a claim form for filing proof of loss. If the claim form is not received within 15 days, You can meet the proof of loss requirement by giving us a written statement of what happened. A written statement must be received within the time shown in 3 below.

2. Next, complete and sign the claim form. If a physician must complete part of the claim form, have the physician complete and sign that part.

3. Finally, return the claim form (with any bills) to the Claims Administrator. The claim form is due:

   (a) within 90 days after the loss occurs; or

   (b) as soon as reasonably possible, but not later than one year after (a) above, unless the claimant is not legally capable.

When Claims are Paid

All Plan benefits will be paid as soon as the Claims Administrative receives acceptable proof of loss.

Direct Payments

Any benefits for hospital, medical, surgical, dental or vision services which You have assigned will be paid to the hospital or the provider of the services. If You have not assigned the benefits, the Claims Administrator, at their option, will pay You or the hospital or the provider of the services. If You used the services of a Preferred Provider, benefits will be paid to the Preferred Provider.

Any other benefits will be paid to You except that benefits unpaid at Your death may be paid, at their option, to:

(a) Your beneficiary; or

(b) Your estate.

If Your beneficiary is unable to give a valid release or if benefits unpaid at Your death are not more than $1,000, we may pay up to $1,000 to any relative of Yours who we find is entitled to the benefit.

Any payment made in good faith will fully discharge us to the extent of the payment.

Examination and Autopsy

We sometimes require that a claimant be examined by a physician chosen by the Claims Administrator. You will not be required to pay for these examinations. Not more than a reasonable number will be required. Where not prohibited by law, an autopsy may be required. You will not be required to pay for this autopsy.

APPEAL RIGHTS

(as Federally Mandated)

Definitions

Capitalized terms have the same meaning as shown in the Plan and the Precertification and Claim Review Procedures provision.

For the purposes of this Appeal Rights provision, the terms **You, Your, Yours** shall include Your authorized representative.

Opportunity To Request An Appeal

You shall have a reasonable opportunity to appeal United's precertification or claim review decisions in accordance with this Appeal Rights provision. As part of the appeal, there will be a full and fair review of the precertification and/or claim review decisions.

The request for an appeal can be written, electronically or orally submitted and should include any additional information You believe may have been omitted from United's review or that should be considered by them.

United of Omaha will establish and maintain procedures for hearing, researching, recording and resolving any appeal. The notification You receive regarding their precertification or claim review decision will include instructions on how and where to submit an appeal.

You will have no later than 180 days from Your receipt of notification of United's precertification or claim review decision to submit a request for an appeal.

The request for an appeal should include:

(a) the name of the patient;

(b) the name of the person filing the appeal if different from the patient;

(c) the Administrative Services Agreement number;

(d) the member number;

(e) the nature of the appeal; and

(f) names of all individuals, facilities and/or services involved with the appeal.

By requesting an appeal, You have authorized United, or anyone designated by them, to review any and all records (including, but not limited to, Your medical records) which United determines may be relevant to Your appeal.

United of Omaha's Response To Appeals

Once Your request for an appeal is received a response will be sent no later than:

(a) 72 hours for Claims Involving Urgent Care;

(b) 30 days for claims and services for benefits requiring precertification (excluding Claims Involving Urgent Care); and

(c) 60 days for claims and services for benefits not requiring precertification.

When United of Omaha makes a determination, United will provide You with:

(a) information regarding United's decision; and

(b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

Please refer to the Precertification and Claim Review Procedures provision.

PRECERTIFICATION AND CLAIM REVIEW PROCEDURES

(as Federally Mandated)

Definitions

Capitalized terms have the same meaning as shown in the Plan.

For the purposes of this provision:

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment, (in whole or in part), for a benefit, including, without limitation, any such denial, reduction, termination of, or failure to provide or make payment that is based upon:

(a) the Covered Person's ineligibility for coverage under the Plan;

(b) United of Omaha's determination that the treatment or service is not a Covered Service under the Plan;

(c) a utilization review determination;

(d) United's determination that the treatment or service is considered an Experimental or Investigational Drug or Treatment; or

(e) United's determination that the treatment is not Medically Necessary.

Additionally, if United of Omaha has previously approved an ongoing course of treatment to be provided over a period of time or a given number of treatments, any reduction or termination of such course of treatment by United (other than by plan amendment or termination) before the end of such period of time or number of treatments is an Adverse Benefit Determination.

Claim or Request Involving Urgent Care means any claim or request for a benefit for medical care or treatment with respect to which the application of time periods for making nonurgent care determinations:

(a) could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or

(b) in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Additionally, if a Physician with knowledge of the Covered Person's medical condition determines that a claim is a Claim or Request Involving Urgent Care, the claim shall automatically be treated as a Claim or Request Involving Urgent Care for the purposes of this provision.

Day(s) means calendar day(s).

For the purposes of these Precertification and Claim Review Procedures**,** the terms **You, Your, Yours** shall include Your authorized representative.

Precertification and Claim Review Procedures

Once United of Omaha receives information necessary to evaluate the precertification request or evaluate the claim, United will make a decision within the time periods set forth below. Please refer to the Utilization Management Provisions, if any; and the Payment of Claims provisions of the Plan.

In the event an extension is necessary due to matters beyond United of Omaha's control, United will notify You of the extension and the circumstances requiring the extension. Except where You voluntarily agree to provide United with additional time, extensions are limited as set forth below.

If an extension is necessary due to Your failure to submit complete information, United of Omaha will notify You of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for United of Omaha to continue processing Your precertification request or claim, the missing information must be provided to United within the time periods set forth below.

You may contact United of Omaha at any time for additional details about the processing of the precertification request or claim.

Claims or Requests Involving Urgent Care

Initial review: 72 hours, unless additional information is requested as set forth below.

If additional information is needed, United of Omaha will notify You within 24 hours of their receipt of the request. Once You receive United's request for additional information, You will be given no less than 48 hours to submit the additional information to United. United will make their determination within 48 hours of receipt of the additional information. If United does not receive the additional information within the specified time period, they will make their determination based upon the available information.

Claims or Requests For Benefits Requiring Precertification (excluding Claims or Requests Involving Urgent Care)

(a) Initial review: 15 days unless additional information is requested as set forth below;

(b) Extension Period: 15 days; and

(c) Maximum number of extensions: one.

If additional information is needed, United of Omaha will notify You within five days of their receipt of the request. Once You receive United's request for additional information, You will be given no less than 45 days to submit the additional information to United. United will make their determination within 15 days of receipt of the additional information. If United does not receive the additional information within the specified time period, they will make their determination based upon the available information.

Claims or Requests For Benefits Not Requiring Precertification

(a) Initial review: 30 days;

(b) Extension period: 15 days: and

(c) Maximum number of extensions: one.

If additional information is needed, United of Omaha will notify You within 30 days of their receipt of the request. Once You receive United's request for additional information, You will be given no less than 45 days to submit the additional information to United. United will make their determination within 15 days of receipt of the additional information. If United does not receive the additional information within the specified time period, they will make their determination based upon the available information.

Claims or Requests for Benefits Involving Concurrent Care

United of Omaha will notify You of an Adverse Benefit Determination regarding a previously-approved ongoing course of treatment or number of treatments sufficiently in advance to allow You to appeal the Adverse Benefits Determination and obtain a determination of Your appeal before such ongoing treatment is terminated or reduced. (Please refer to the Appeal Rights provision for additional information.)

If You request to extend the course of treatment beyond the period of time or number of treatments that were originally approved by United of Omaha, and such request is a Claim Involving Urgent Care, United will notify You of their determination within 24 hours of receipt of Your request, provided that they receive Your request for extension at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If United does not receive Your request within the 24 hour period, they will treat Your request as described in the section entitled "Claims Involving Urgent Care."

If You request to extend the course of treatment beyond the period of time or number of treatments that were originally approved by United of Omaha and such request is not a Claim Involving Urgent Care, United will treat Your request as described in the section herein entitled "Claims For Benefits Requiring Precertification" or "Claims For Benefits Not Requiring Precertification," whichever is applicable to the request.

Precertification Denials and/or Claim Denials

If a request for precertification or a claim is denied or partly denied, You will receive a written or electronic notice of the denial, which will include:

(a) the specific reason(s) for the denial;

(b) reference to the specific Plan provisions on which the denial is based;

(c) if applicable, a description of any additional material or information necessary to complete the claim and the reason United of Omaha needs the material or information;

(d) a description of the appeal procedures; the applicable time frames, including Your right to request an appeal within 180 days and Your rights to bring a civil action following the appeal process; and

(e) any other information which may be required under state or federal laws and regulations.

Additionally, if United of Omaha makes an Adverse Benefit Determination, You will receive a statement of Your right to receive, upon request and free of charge, any internal rule, guideline, protocol or other similar criterion United used in making an Adverse Benefit Determination.

Furthermore, if United of Omaha makes an Adverse Benefit Determination based upon their determination that:

(a) the treatment and/or service is considered an Experimental or Investigational Drug or Treatment; or

(b) the treatment and/or service is not Medically Necessary;

United of Omaha will include a statement that an explanation of the scientific or clinical judgment for such determination will be provided to You upon request, free of charge.

Appeals

If a request for precertification or a claim is denied or partly denied, You shall have a reasonable opportunity for an appeal and a right to a full and fair review. Please refer to the Appeal Rights provision.

QUALITY ASSURANCE AND QUALITY IMPROVEMENT

United of Omaha has developed and maintain quality assurance and quality improvement programs that are intended to:

(a) measure and evaluate the quality and outcomes of health care provided to Covered Persons; and

(b) help improve the process and outcomes related to provision of health care to Covered Persons.

United's quality assurance and quality improvement programs do not replace the care received from the Covered Person's Physician. The Covered Person and his or her Physician remain in charge of the Covered Person's health care and health care treatment plan.

The quality assurance and quality improvement programs provide assistance in managing Covered Persons' use of health care services to help attain*:*

(a) quality care and service;

(b) cost-effectiveness; and

(c) access to qualified providers.

FRAUD NOTICE

Definition

For the purposes of this provision, the following term has the following meaning:

Fraud means an intentional act of deception, misrepresentation or concealment committed in order to obtain or attempt to obtain benefits or services under the Plan.

Stop Health Care Fraud

Fraud increases the cost of health care for everyone. If You suspect that a Physician, pharmacy, Hospital or other health care provider has charged You or Your dependent for services You or Your dependent did not receive, billed You or Your dependent more than once for the same service or misrepresented any information, do the following:

(a) Call the provider and ask for an explanation. There may be an error.

(b) If the provider does not resolve the matter, call United of Omaha at 800-936-9396 and explain the situation; or

(c) Write to United of Omaha at:

Special Investigations Department
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

Penalties For Fraud

(a) Anyone who intentionally falsifies a claim to obtain Plan benefits may be prosecuted for Fraud.

(b) United's Special Investigations Department may investigate anyone who uses an identification card if such person:
   (1) tries to obtain services for a person who is not a Covered Person; or
   (2) is no longer covered and tries to obtain benefits.

(c) We may also take appropriate action against anyone who falsified a claim for benefits under the Plan.

(d) The following is added to any provision describing when coverage ends for employees and/or dependents:

Fraud by You or Your dependent is a basis for ending Your or Your dependent's coverage under the Plan.

STANDARD PROVISIONS

Changes in Plan Benefits

Plan benefits may be changed (including reducing or termination benefits or increasing contribution) at any time.

A change in Plan benefits:

(a) does not require the consent of any Covered Person or beneficiary; and

(b) must be in writing.

A change may affect any class of Covered Persons, including retirees if retired coverage is included in the Plan.

Applications

Any application of a Covered Person may be used to contest the validity of coverage, reduce coverage or deny a claim. The Plan will furnish You or Your beneficiary with a copy of that application. A person's application may not be used to contest or reduce coverage which has been in force for two years or more during that person's lifetime. However, if You or Your dependent is not eligible for coverage, there is no time limit on the Plan's right to contest coverage or deny a claim.

Statements in an application are treated as representations, not as warranties.

Administrative Services Agreement No.
which is comprised of

Group Identification Number G00059K1 and
Plan Identification Number MEDPPO

Self-Funded By

Cameron County
Cameron County Courthouse
964 East Harrison St.
Brownsville, Texas 78520

Claims Administered By

United of Omaha Life Insurance Company

Publication Date: April 12, 2007

(Please keep with your booklet)

Cameron County

Important Change(s) to Your Plan

Effective February 1, 2007

UTILIZATION MANAGEMENT PROVISIONS

UTILIZATION REVIEW

This Plan Change is made a part of an Administrative Services Agreement which is comprised of Group Identification Number G00059K1 and Plan Identification Number MEDPPO.

This Plan Change is effective the later of February 1, 2007, or the day You become covered under the Plan.

The Precertification requirement for Outpatient High End Radiology is being removed from the Utilization Management Provisions.

This **UTILIZATION MANAGEMENT PROVISIONS** replaces any previous **UTILIZATION MANAGEMENT PROVISIONS** in the Booklet to which it is attached.

In the event of a conflict between this Plan Change and any other provision of the Plan, including the Booklet, this Plan Change shall control. This Plan Change shall be subject to all provisions of the Plan, including the Booklet, not in conflict with this Plan Change.

UTILIZATION REVIEW

Utilization Review Procedures are only intended to determine if health care services or supplies are Medically Necessary under the terms of the Plan.

Before the services or supplies are received, all Hospital Confinements, Outpatient Surgical Procedures and Specialized Services and Supplies identified in these provisions must be pre-certified by United as Medically Necessary. **You, not Your Physician, are responsible for making sure a pre-certification determination has been made**. However, You, Your representative or Your Physician may initiate the pre-certification.

Pre-certification of a proposed service or supply as Medically Necessary through the Utilization Review process <u>does not</u> necessarily mean that benefits are payable. Confirmation of a person's eligibility for Plan coverage for a particular service or supply, and fulfillment of all other Plan requirements, are also necessary for benefits to be payable.

<u>Definitions</u>

Care Review Unit means United's Care Review Unit staff or a qualified party or entity named by them. For the toll-free phone number, refer to Your identification card or contact Your Plan Administrator.

Outpatient Mental and Nervous Disorders or Alcohol and Drug Abuse and/or Substance Abuse Therapy means any individual, group, family or intensive outpatient therapy for the treatment of a Mental and Nervous Disorder or Alcohol and Drug Abuse and/or Substance Abuse, regardless of how it is classified.

Outpatient Surgical Procedures means the outpatient surgical procedures listed below which are performed:

(a) in an ambulatory surgical facility;

(b) in a Physician's office or clinic; or

(c) on an outpatient basis in a Hospital.

Outpatient surgical procedures include:

(a) carpal tunnel release - surgery to relieve a pinched nerve in the hand;

(b) cochlear implants - insertion of small computer device to transmit to the auditory nerve;

(c) endometrial ablations - complete removal of the lining of the uterus;

(d) hysterectomy - surgical removal of the uterus;

(e) pelvic laparoscopy - examination of the female organs by a scope;

(f) tonsillectomy with/without adenoidectomy - surgical removal of the tonsil and adenoids;

(g) septoplasty - surgical procedure to straighten the nasal septum; and

(h) UPP (uvulopalatopharyngoplasty) or laparoscope aided UPP - removal of a portion of the uvula and soft palate.

Specialty Drugs and Medicines means the injectable specialty drugs or medicines for the ongoing treatment of a chronic condition which are given:

(a) in a Physician's office or clinic; or

(b) in a home health care setting.

Specialty Drugs and Medicines includes, but is not limited to, those used for the following:

(a) asthma;

(b) inflammatory bowel disease;

(c) growth hormone deficiency;

(d) neurologic disease;

(e) osteoporosis;

(f) psoriasis;

(g) rheumatoid arthritis;

(h) immune deficiency;

(i) injectable drugs or medications with uses for indications excluded under the Plan;

(j) any injectable drugs or medications billed at $1000 or more.

Specialized Services and Supplies means the services or supplies listed below:

(a) home health care;

(b) outpatient hospice care;

(c) durable medical equipment: the purchase or rental of any single piece of durable medical equipment with a purchase price of $1,000 or more; and

(d) prosthetics.

Pre-certification Requirements

You must pre-certify with United the following:

1. Hospital Confinement, Skilled Nursing Facility confinement and inpatient Hospice Care Facility due to a Sickness or Injury;
2. Hospital Confinement and partial hospitalization for Mental and Nervous Disorders or Alcohol and Drug Abuse and/or Substance Abuse;
3. Outpatient Mental and Nervous Disorders or Alcohol and Drug Abuse and/or Substance Abuse Therapy;
4. Specialty Drugs and Medicines;
5. Outpatient Surgical Procedures; and;
6. Specialized Services and Supplies.

You, Your representative or Your Physician must request pre-certification from the Care Review Unit. The Care Review Unit will advise You and Your Physician of the review decision.

United recommends pre-certification be initiated at least seven (7) days before the Hospital Confinement, Outpatient Surgical Procedure, Outpatient Mental and Nervous Disorders or Alcohol and Drug Abuse and/or Substance Abuse Therapy or Specialized Services and Supplies begin or are received. If not pre-certified at least one (1) business day prior, a penalty will apply.

Within two (2) business days, or as soon as reasonably possible for a Medical Emergency, You, Your representative or Your Physician must notify the Care Review Unit of the Hospital Confinement, the Outpatient Surgical Procedures and/or the Specialized Services or Supplies. If not pre-certified within this time frame, a penalty will apply. The Care Review Unit will advise You and Your Physician of the review decision.

If a visit to a Hospital Emergency room exceeds 24 hours, any additional observation in the emergency room must be pre-certified. This is applicable even if the visit does not result in a Hospital Confinement.

Effect on Benefits

The following penalties will apply if services are not properly pre-certified by United.

1. For Hospital Confinement due to a Sickness or Injury, Skilled Nursing Facility, inpatient Hospice Care Facility, Hospital Confinement and Partial Hospitalization for Mental and Nervous Disorders or Alcohol and Drug Abuse and/or Substance Abuse:

   Prior to admission, if a Covered Person does not first initiate the required pre-certification and it is determined that the Hospital Confinement and related Covered Services were:

   (a) Medically Necessary, benefits payable for the room and board will be reduced by $500; or

   (b) not Medically Necessary, no benefits are payable.

During the confinement, if a Covered Person has received pre-certification for a specified number of days and wants to stay for additional days, the additional days must be approved by United as described in the Pre-certification Requirement section. If the additional days are not pre-certified by United and subsequent review determines the days were;

(a) Medically Necessary, benefits payable for the room and board will be reduced by $500; or

(b) not Medically Necessary, no benefits will be payable.

Note: For Services that could have been provided on an outpatient basis, but are performed in an inpatient/Hospital Confinement setting when Hospital Confinement was determined to not be Medically Necessary, the room and board will not be payable. Expenses for other Covered Services provided during the Hospital Confinement (including but not limited to x-ray and laboratory services) will be considered in accordance with applicable Plan provisions.

2. For Outpatient Surgical Procedures, Outpatient Mental and Nervous Disorder/Alcohol and Drug Abuse and/or Substance Abuse, Specialized Services or Supplies, or Non-Retail Specialty Drugs and Medicines:

   Prior to treatment, if a Covered Person does not first obtain the required pre-certification and it is determined that the Covered Services were:

   (a) Medically Necessary, benefits payable will be reduced by $500; or

   (b) not Medically Necessary, no benefits are payable.

   During the treatment, if a Covered Person has received pre-certification for a specified number of days/visits/treatments and wants additional days/visits/treatments, the additional days/visits/treatments must be approved by United as described in the Pre-certification Requirement section. If the additional days/visits/treatments are not pre-certified by United and subsequent review determines the days/visits/treatments were:

   (a) Medically Necessary, benefits payable will be reduced by $500 per days/visits/treatments; or

   (b) not Medically Necessary, no benefits will be payable.

When benefits are reduced in accordance with this Effect on Benefits section, the reduction will not be used to satisfy any deductible or out-of-pocket limit shown in the Schedule.

Exceptions

1. Pre-certification is **not** required when the Covered Person has Medicare coverage which:

   (a) has primary responsibility for the Covered Person's claim; and

   (b) must pay its full benefits before Plan benefits are paid in accordance with the Medicare Coordination of Benefits provision of the Plan.

2. Pre-certification is **not** required for the initial 48-hour inpatient Hospital Confinement for a vaginal delivery or the 96-hour inpatient Hospital Confinement for a Cesarean section delivery.

3. Pre-certification is **not** required for services or supplies performed or provided, outside the United States, Mexico and Canada or any state, district, province, territory or possession thereof.

Request for an Appeal of United's Utilization Review Decision

You, Your representative or Your provider of health care have the right to request an appeal regarding United's Utilization Review decisions. The request should be submitted in writing and should include any additional information that may have been omitted from United's review or that should be considered by United. Requests should be sent to:

Mutual of Omaha
Medical Management
Appeals and Grievance
PO Box 31640
Omaha, NE 68131-0640

You may also call the toll-free phone number listed on Your identification card for additional information regarding United's appeal process.

Administrative Services Agreement
which is comprised of

Group Identification Number G00059K1
and
Plan Identification Numbers MEDPPO

Publication Date: February 24, 2007