Early Retiree Medical Plan (Non-Medicare Eligible Plan)

Highlights

The provisions of this section are generally effective May 1, 2012. For information on coverage and benefits prior to May 1, 2012, please refer to the 2011 Summary Plan Description.

Depending on your age at retirement, you may have the option to continue many of your Turner Benefits. Turner offers Early Retiree Medical Benefits to help you with the cost of medical care for yourself and your eligible dependents as long as they are not Medicare-eligible. For a period of time, you’ll also have the option of continuing your dental and vision coverage, as well as Health Care Flexible Spending Account (FSA) contributions, through COBRA (see page 173).

<table>
<thead>
<tr>
<th>Plan Overview</th>
<th></th>
</tr>
</thead>
</table>
| **Medical Care** | • If you retire at age 55 with at least 15 years of service and are not eligible for Medicare, you may continue your coverage under medical options similar to those that were available to you as an active employee. Once you become eligible for Medicare, you are eligible for the Towers Watson OneExchange.  
• If you retire at age 65 or later with at least 6 years of service, you are eligible for coverage under the OneExchange Program.  
• For employees hired on or after August 1, 2010, only years of service earned after age 30 will be considered for purposes of determining retiree medical eligibility. |
| **Dental Assistance Plan** | You may be eligible to purchase dental coverage under COBRA (see page 177). |
| **Vision Plan** | You may be eligible to purchase vision coverage under COBRA (see page 177). |
| **Employee Assistance Program (EAP)** | You must be an active employee to participate in the EAP. |

Please refer to the Administrative Information section of this Summary Plan Description for additional information on claims procedures, plan administration, your rights under the plan, and Turner’s rights under the plan, including the ability to amend or terminate the plan or any component of it at any time in accordance with applicable law and the discretion to interpret all plan documents and make factual determinations. If there is a conflict between this Summary Plan Description and the official plan documents, the plan documents will govern.

- Once you become Medicare eligible, (you turn age 65 or you meet the eligibility requirements before age 65 due to disability), Medicare will become your primary medical coverage. This means when you have medical claims, Turner’s Retiree medical plan will process your medical claims under the assumption you have enrolled in Medicare Parts A & B.
- If you or one of your dependents become eligible for Medicare before age 65, you will no longer be eligible for Turner’s Early Retiree Medical plan. Please contact the Benefit Service Center so that we can help move you or your Medicare eligible dependents to our OneExchange Program. It is your responsibility at that time to enroll in Medicare Parts A & B.
- If you die while you are covered under Turner’s Early Retiree Medical plan, your surviving spouse or Registered Domestic Partner will remain eligible for coverage during his or her lifetime. Your dependent children will also remain eligible as long as they continue to meet the plan’s eligibility requirements. Please refer to your Summary Plan Description online at www.turnerbenefits.com for more details on eligibility.
- If you elect to drop or discontinue coverage under Turner’s Early Retiree Medical plan, you will not be able to re-enroll at a later date.

If You Are Approaching Medicare Eligibility – or Are Already Medicare Eligible

You generally become eligible for Medicare when you reach age 65. See www.medicare.gov for other times, such as
when you become disabled, that you might become eligible for Medicare. If you are eligible for Medicare, you will be eligible to enroll with our partner, OneExchange, who helps you select the best Medicare Supplement plan option for you. The OneExchange Model is designed to supplement the benefits provided by Medicare Parts A & B. You will have more choice, better coverage, and greater financial flexibility as a Medicare-eligible retiree.

You will receive information about the OneExchange Program approximately 90 days prior to becoming Medicare-eligible based on your age. If you or one of your dependents become eligible for Medicare before age 65, you must contact the Benefits Service Center so that we can help move you or your Medicare-eligible dependents to our OneExchange Program.

Those who become eligible for Medicare must enroll in Medicare Parts A & B, which will become the primary medical coverage. You can learn more about Medicare coverage on the Medicare website, www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227) to speak to a Medicare Customer Representative. Those not yet eligible for Medicare can remain covered under one of Turner’s non-Medicare retiree plans until they become Medicare-eligible.

Your Choices
When you notify your local Human Resources representative and the Benefits Service Center that you intend to retire, the Benefits Service Center will send you personalized retirement benefits information that will help you choose from the various options you may have, including:

- Enrolling in the Early Retiree Medical Plan
- Enrolling in the OneExchange Program
- Electing COBRA medical, dental, or vision coverage

Medical Coverage Categories
If you enroll in the Retiree Medical Plan, you may choose coverage for:

- You (Retiree)
- You and your spouse (Retiree + Spouse)
- You and one or more children (Retiree + Child(ren))
- You and your family (Retiree + Family)

For a complete description of eligible dependents, refer to Your Benefit Program, beginning on page 1.

For employees hired on or after August 1, 2010, only years of service earned after age 30 will be considered for purposes of determining retiree medical eligibility (including OneExchange Program).

Medical Plan Options
If you retire at age 55 with at least 15 years of service and are not eligible for Medicare, you are eligible to continue coverage under similar medical options to those that were available to you as an active employee. You may choose coverage under one of the following options (see page 147 for more detailed information about any of the options):

- Plan 1 and Plan 2 are Preferred Provider Organization (PPO) Options
A PPO is a pre-screened network of providers — physicians, hospitals, labs, and other medical professionals — who have agreed to provide services at lower, pre-negotiated rates as an incentive to be selected by Turner employees. You can use any provider you choose, but you generally receive a higher level of benefits when you use in-network providers.

- Plan 3 is a High Deductible Health Plan (HDHP) with Health Reimbursement Account (HRA). Plan 3 gives you access to the same network of doctors and health care providers as Plan 1 and Plan 2, but has higher deductibles and out-of-pocket costs than Plan 1 or Plan 2. However, Plan 3 includes a Health Reimbursement Account (HRA) to help you pay for "up front" medical expenses such as deductibles and office visit copays.

- No Coverage. If you do not elect coverage at the time you retire — or if you discontinue coverage any time after you retire — you will not be able to re-enroll in medical coverage at a later date.

If you retire at age 55 with at least 15 years of service or at age 65 with at least 6 years of service and you are eligible for Medicare, you are eligible for coverage under the OneExchange Program. This plan is designed to supplement the benefits provided by Medicare Parts A & B. You must enroll in both Part A and Part B to receive full benefits under the OneExchange Program.
When you or one of your dependents becomes eligible for Medicare, that person is automatically eligible for the OneExchange Program and you must notify the Benefits Service Center. All remaining participants will continue in their current coverage.

If you elect to drop or discontinue coverage — you will not be able to re-enroll in Retiree Medical Coverage at a later date.
## Medical Benefits

### Medical Care for Retirees Not Eligible for Medicare

The following table summarizes the benefits offered under the Plan 1, Plan 2 and Plan 3 options. You may not be eligible for all options shown.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>PLAN 1</th>
<th>PLAN 2</th>
<th>PLAN 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Provider</td>
<td>In-Network Provider</td>
<td>In Network Provider</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$250/person $750/family</td>
<td>None</td>
<td>$500/person $1,500/family</td>
</tr>
<tr>
<td>Turner’s Contribution to HRA</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>$500 – Employee</td>
</tr>
<tr>
<td>Annual Out-of Pocket Maximum</td>
<td>$2,500/person $5,000/family</td>
<td>$5,000/person $10,000/family</td>
<td>$1,000/person $5,000/person</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$2,000/family $10,000/family</td>
<td>$1,000/person $5,000/person</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$2,000/person $10,000/family</td>
</tr>
<tr>
<td>Lifetime Benefit Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Hospital Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Charges^2</td>
<td>90% after deductible</td>
<td>70% of Eligible Expenses after deductible</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Charges</td>
<td>90% after deductible</td>
<td>70% of Eligible Expenses after deductible</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance^3</td>
<td>90% no copay</td>
<td>90% no copay</td>
<td>100% no copay</td>
</tr>
<tr>
<td>Emergency Room and Physician^3</td>
<td>$200 copay; waived if admitted</td>
<td>$200 copay; waived if admitted</td>
<td>$200 copay</td>
</tr>
<tr>
<td>Benefit</td>
<td>PLAN 1</td>
<td>PLAN 2</td>
<td>PLAN 3</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------</td>
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<td>--------</td>
</tr>
<tr>
<td><strong>Office Visit for Diagnosis, Care and Consultations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-specialist:</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>$15 copay$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$25 copay$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Wellness/Preventive Care Visits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-specialist:</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>$15 copay$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Well-Baby Care (until age 6) and Immunizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-specialist:</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>Allergy Injections</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-specialist:</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>Employee Assistance Program</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible employees and dependents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Inpatient &amp; Outpatient:</td>
<td>70%</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Drug/Alcohol Rehab</strong></td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Benefit</td>
<td>PLAN 1</td>
<td>PLAN 2</td>
<td>PLAN 3</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>Outpatient Drug/Alcohol Rehab</strong></td>
<td>$15 copay</td>
<td>70% of Eligible Expenses after deductible</td>
<td>$10 copay</td>
</tr>
<tr>
<td><strong>Maternity Office Visits</strong></td>
<td>$15 copay for 1st visit only; then 90% after deductible</td>
<td>70% of Eligible Expenses after deductible</td>
<td>$10 copay for 1st visit only; then 100%</td>
</tr>
<tr>
<td><strong>Maternity Delivery</strong></td>
<td>90% after deductible</td>
<td>70% of Eligible Expenses after deductible</td>
<td>100% no copay</td>
</tr>
<tr>
<td><strong>Chiropractic</strong></td>
<td>$25 copay specialist; Limit 25 visits/year</td>
<td>70% of Eligible Expenses after deductible; Limit 25 visits/year</td>
<td>$10 copay; Limit 25 visits/year</td>
</tr>
<tr>
<td><strong>Prescriptions</strong></td>
<td>$5 – Tier 1</td>
<td>70% of Eligible Expenses after deductible</td>
<td>$5 – Tier 1</td>
</tr>
<tr>
<td><strong>Retail Pharmacy</strong></td>
<td>$30 – Tier 2</td>
<td>$30 – Tier 2</td>
<td>$30 – Tier 2</td>
</tr>
<tr>
<td><strong>Mail-Order Program</strong></td>
<td>$60 – Tier 3</td>
<td>$60 – Tier 3</td>
<td>$60 – Tier 3</td>
</tr>
</tbody>
</table>

1. Copays for physician services do not count toward the out-of-pocket maximum.
2. **A $250 penalty is applied if Personal Health Support is not notified. Call 1-877-632-2273.**
3. Must qualify as a true medical Emergency to receive the coverage amount in this chart.
4. Each visit to a physician’s office is subject to the copay amount, without regard to the number of services performed.
5. Based on recommended benefits set out by the U.S. Preventive Services Task Force.
6. Excludes separate visits for lab and X-ray services.
Coverage Options

Under Plan 1, Plan 2, and Plan 3 you have access to a network of doctors, hospitals, and other medical providers who have agreed to provide services at a negotiated cost. You receive a higher level of benefits when you use network providers.

The plans also give you the flexibility to use providers outside of the network. When you use out-of-network providers, most expenses are reimbursed at a lower level. You may use both in network and out-of-network providers for the same medical condition.

Along with the flexibility to choose which providers are in-network or out-of-network each time you need care, you also have more responsibility for knowing which providers are in the network. You will not have a Primary Care Physician referring you to in-network doctors, so it is up to you to do your own planning and screening.

You can find a provider directory to help you through this process by going online to www.turnerbenefits.com, clicking on the link to “Benefits Providers” and then going to the United Healthcare website.

When visiting a foreign country, you are generally covered on the same basis as if you were visiting out-of-network providers in the U.S.

Plan 1

Each time you receive medical care, you choose either an in-network or an out-of-network provider.

- **When you use in-network providers**, you will pay a copay for office visits. Most other eligible in-network services are paid at 90% after your in-network deductible of $250 per person or $750 for a family.

- **When you use out-of-network providers**, the plan generally pays 70% of eligible expenses after you meet your out-of-network deductible of $500 per person or $1,500 for a family.

Plan 2

Each time you receive medical care, you choose either an in-network or an out-of-network provider.

- **When you use in-network providers**, you will pay a copay for office visits. The plan pays 100% of most other eligible in-network services. There is no in-network deductible.

- **When you use out-of-network providers**, the plan pays 70% of eligible expenses after you meet your out-of-network deductible of $500 per person or $1,500 for a family.

Plan 3

Plan 3 has many features in common with Plan 1 and Plan 2, including access to the same network of providers. You must pay a high annual deductible before receiving benefits under Plan 3. When you choose this plan, Turner also provides you with a Health Reimbursement Account (HRA) to help you pay part of that deductible as well as some of your eligible medical expenses that would not otherwise be covered under Plan 3. The amount you receive depends on your coverage level (see page 25). In addition, when you use in-network providers, Plan 3 pays 100% of annual wellness exams and some preventive care expenses — without reducing your HRA.

When you use in-network providers, payment for your eligible medical expenses is automatically deducted from your HRA until you have used the entire account. When you use out-of-network providers, you may need to pay the provider and file a claim for reimbursement from your HRA.

If you spend the entire amount in your HRA during the year, you will be responsible for 100% of any additional medical expenses you have during the year — until you reach your Plan 3 deductible. When you use in network providers, your Plan 3 annual deductible will be $1,000 per person or $3,000 for a family. If you use out-of-network providers, you must pay an annual deductible of $2,000 per person or $6,000 for a family.

After you reach your deductible, the plan begins paying benefits for your eligible expenses. (You may want to set aside pre-tax dollars in your Health Care Flexible Spending Account to help you pay the difference between your HRA and your deductible.) If you don’t use all of the HRA money in your account, whatever is left at the end of the year rolls over to your HRA for the next year, for as long as you participate in Plan 3.

Health Reimbursement Account (HRA) (Plan 3 only)

Turner contributes funds to your HRA each year based on the coverage level you select.
<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Turner's Annual HRA Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$500</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$1,000</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$1,000</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

If you increase your coverage level, an additional amount will be placed in your HRA. The increase will be prorated monthly based on the difference between the amount that was placed in your HRA at the beginning of the year and what would have been placed in your account if you had elected the additional coverage at that time.

For example, if you had enrolled for Employee Only coverage on January 1 and you change to Employee + Spouse coverage effective July 1, an additional $250 (6/12 of $500) will be placed in your HRA. In addition, if your coverage level changes on 7/14, then it would retro back to first of the month so in this case would be 7/1. If you decrease your coverage level, the amount placed in your HRA for the year will be prorated based on the effective date of the change.

You can use your HRA funds to pay for eligible medical expenses such as deductibles, office visit copays, and most other out-of-pocket medical expenses (but not prescription drug copays). Long-term care expenses cannot be reimbursed with HRA funds.

As long as you have money in your account, you have two ways to access your HRA funds:

- Use your Consumer Accounts Card (see page 84), which will automatically debit your HRA balance at the point of purchase, or
- Ask your provider to submit a claim. You will then be reimbursed from your HRA if funds are available.

If you don’t spend your entire HRA during the year, the unused portion will roll over and be added to your HRA for the next year — as long as you participate in Plan 3. If you do not enroll in Plan 3 for the next year, you will not be able to access any balance remaining in your HRA. However, if you move back to Plan 3 the following year, you will again have access to that unused portion of your HRA.

For example, suppose you enrolled in Plan 3 in 2015 and had money left in your HRA at the end of the year. If you enroll in Plan 2 in 2016, you will not have access to your unused 2015 HRA dollars during 2016. However, if you move back to Plan 3 in 2017, you will have access to your new HRA for 2017 as well as any unused portion of your 2015 HRA.

If your employment terminates for any reason, any remaining funds in your HRA will be forfeited and you will NOT have access to these funds. If you incur a claim prior to your termination, you must submit that claim within two years from the date of service. If you retire from Turner and continue in Plan 3 through the Early Retiree Medical Plan, any remaining unused balance will carry over, as long as you are enrolled in Plan 3.

If you have an HRA and a Health Care Flexible Spending Account (FSA), funds will be deducted from your HRA account before they are deducted from your medical FSA.

**Copays**

A copay is a set fee that you pay for a medical service such as a routine office visit. These copays apply only for services you receive from the in-network providers. The amount of your copay is generally determined by the coverage option you choose.

**Coinsurance**

Coinsurance is the percent of your eligible expenses that you must pay after the annual deductible, if applicable. The amount of coinsurance you pay varies based on the use of in-network and out-of-network providers under each plan option. See the comparison chart on pages 21-23 for applicable coinsurance under each plan.
**Annual Deductible**

The annual deductible is the amount you pay before the plan begins to pay benefits for covered health services. The amount of annual deductible you are required to pay, if any, is generally determined by the medical coverage option you choose and whether you use in-network providers. You do not have to meet an annual deductible under most HMO plans or when you use in-network providers under Plan 2.

The deductible only needs to be satisfied once each calendar year for a particular covered individual regardless of the number of different disabilities or types of expenses that person incurs.

If three or more covered members of your family incur eligible expenses that are used toward satisfying their individual deductibles during the same calendar year, and the sum of these expenses exceeds the family deductible, no further deductibles will be required for your family for the remainder of the calendar year. This is true regardless of whether a specific family member has met the individual deductible.

For example, if your individual deductible is $250 and your family deductible is $750 and you incur eligible expenses of $195, and three of your dependents incur eligible expenses of $180, $240, and $135 for a total of $750, the deductible for you and all your dependents would be satisfied for the remainder of the calendar year.

If two or more covered members of your family are injured in the same accident and care is received out-of-network, you pay only one individual deductible amount in that calendar year for all eligible expenses resulting from that accident. In other words, all eligible expenses of the individuals injured in the common accident are combined for the purpose of determining the deductible amount you pay, just as if only one person had been injured.

**Annual Out-of-pocket Maximum**

The annual out-of-pocket maximum is the most you pay for coinsurance for eligible in-network expenses and eligible out-of-network expenses in a calendar year. When the amount you have spent in a calendar year for deductibles and coinsurance for Covered Health Services exceeds the annual out-of-pocket maximum under the plan you elect, any further eligible expenses will be reimbursed at 100% of the amount for the rest of that calendar year. You are also responsible for any out-of-network expenses over the eligible amount.

There are separate maximums for in-network and out-of-network eligible expenses. Expenses for Mental Health Services and Substance Use Disorder Services are excluded from the out-of-pocket maximum.

**Personal Health Support**

You must notify Personal Health Support before receiving certain covered health services from either in-network or out-of-network providers. If you do not notify Personal Health Support, your benefits may be reduced or denied. It's a good idea to contact Personal Health Support to confirm that any health services you plan to receive are covered services, even if the services you plan to receive do not require notification. Personal Health Support can also tell you if limitations or exclusions apply to the services you plan to receive. You'll find contact information for Personal Health Support in your Benefit Provider Directory.

If you participate in Plan 1, Plan 2 or Plan 3, you must notify Personal Health Support before receiving any of the following services:

- Inpatient services including:
  - Hospital confinement, including rehabilitation confinements
  - Skilled Nursing Facility confinements
  - Inpatient hospice

- Outpatient services involving the following parts of the body:
  - Abdomen
  - Back
  - Ear, nose, and throat
  - Female pelvic
  - Foot
- Heart
- Knee/hip
- Rectum

- Outpatient Skilled Care
- Outpatient hospice
- Organ/Tissue transplant services
- Pregnancy – Notify Personal Health Support during the first trimester to participate in special prenatal programs.
- Delivery of a Child – if the inpatient care for the mother or child is expected to continue beyond:
  - 48 hours following a normal vaginal delivery or
  - 96 hours following a cesarean section

You must notify Personal Health Support when inpatient care for either the mother or child will continue beyond the 48 or 96 hour limits.

The Medical Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth, for the mother or newborn child, to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours, as applicable).

In any case, the plans may not, under federal law, require a provider to obtain authorization for prescribing a length of stay equal to or less than the above in connection with the birth.

**Designated Network Facilities and Other Providers**

If Personal Health Support believes your medical condition needs special services, they may direct you to a Designated Network Facility or other provider they choose. Personal Health Support may direct you to an out-of-network facility or provider if you need certain complex services that no network facility in your area can provide. To receive in-network benefits in either situation, you must receive services for that condition from the Designated Network Facility or other provider chosen by Personal Health Support.

**Emergency Care**

In the case of a true medical Emergency in-network benefits are paid for Emergency Health Services, even when services are provided by an out-of-network provider.

If you are admitted to the hospital after receiving emergency care, you must notify Personal Health Support within 2 business days or on the same day of admission, if reasonably possible. To continue to receive in-network benefits in an out-of-network hospital, you may be required to transfer to an in-network hospital as soon as it is medically appropriate to do so. Out-of-network benefits may be available if you elect to remain in an out-of-network hospital after that date.

**Tools and Resources**

**Online**

When you log on to [www.turnerbenefits.com](http://www.turnerbenefits.com) and choose the Medical-UHC link on the homepage you can:

- Learn about health care prices, compare prescription drug costs and estimate the cost of treatments, including the discounts available to you through the large, national network
- Search for providers and evaluate quality information for hospitals
- Use personal health tools including health calculators and drug interaction tools

**Mail**

You receive the following information through the U.S. Mail:
• Health Statements are generated based off the Medical claim receipt date and whether adverse or not (patient responsibility), and can generate as often as weekly on up to quarterly depending on the claim activity on the account. If the member has an adverse medical claim (owes something other than copay) then it is a 30 day (monthly) generation. If they have only non-adverse medical claims, or only financial (HRA/FSA etc) claims then it would be 90 days (quarterly). If they have no claims, then it would be longer until they do. If the member has elected EOBs to be mailed via myuhc.com, that makes the claim non-adverse, so it falls to the 90 day timing.

Phone

A full-service Customer Care Center is available to you. When you call the phone number listed in your Benefit Provider Directory (or on your United Healthcare Medical ID card), a representative can help you with:

• General questions and information
• 24-hour Nurse Line with registered nurses who listen to your concerns and provide information to help you choose the right level of care for your situation
• 24-hour pharmacy information that helps you locate a pharmacy, place mail order refills or request forms.

Eligible Expenses

Eligible expenses are charges for covered health services that are provided while the Plan is in effect, as determined as follows:

• For covered health services provided by an in-network provider, eligible expenses are the negotiated rates agreed to by the in-network provider.
• For covered health services provided by a non-network provider, eligible expenses are:
  o The negotiated rates agreed to by the non-network provider and either UHC or one of its vendors, affiliates or subcontractors, at the discretion of UHC, or
  o If rates have not be negotiated, then one of the following amounts:
    - For covered health services other than those further specified below, eligible expenses are determined based on competitive fees in that geographic area. If no fee information is available for a covered health service, the eligible expense is based on 50% of billed charges, except that certain eligible expenses for Mental Health Services and Substance Use Disorder Services are based on 80% of the billed charge;
    - For Mental Health Services and Substance Use Disorder Services, the eligible expense will be reduced by 25% for covered health services provided by a psychologist and by 35% for covered health services provided by a masters level counselor;
    - For covered health services that are pharmaceutical products, eligible expenses are determined based on 100% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. When a rate is not published by CMS for the service, UHC will use the gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by the RJ Health Systems, Thomas Reuters (published in its Red Book) or UHC based on internally developed pharmaceutical pricing resource.

The plan provides protection for eligible expenses resulting from non-occupational disabilities ranging from the common cold to mental illness, cancer, and other serious diseases and accidents, and includes:

Hospital Care

• Charges for a physician, surgeon, or anesthesiologist
• Charges for hospital room and board, including general nursing services (not including daily room and board charges in excess of the semi-private rate when private accommodations are used)
• Outpatient surgery
• Charges for a hospital
- Charges for necessary miscellaneous hospital services and supplies
- Charges for diagnostic, X-ray, and laboratory services
- Charges for therapy by X-ray, radium, and radioactive isotopes
- Charges for anesthesia, oxygen, blood and blood plasma, and their administration
- Reconstructive surgery for mastectomy will be covered for the reconstruction of the breast on which a mastectomy has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance (In addition, prostheses and physical complications during all stages of mastectomies and lymphedemas are covered.)

**Emergency Care**
- Foreign claims are covered for emergent/non-emergent care out of the country. **Please note** You may be required to pay the provider up-front and submit claims for reimbursements to the Plan Administrator.
- Charges for emergency room services in the case of a true medical Emergency
- Charges for services at Urgent Care Centers
- Professional ambulance service provided by a local firm
- Emergency transportation charges by a regularly scheduled airline or railroad from the place where the covered person becomes disabled to the nearest hospital qualified to supply treatment for the accident or illness
- Air ambulance transportation when meeting Covered Health Services/Eligible Expenses definitions criteria

**Physician Office Care**
- Charges for a physician
- Treatment of a sickness or injury
- Wellness benefits as set out by the U.S. Preventive Services Task Force
  - Charges for preventive care services
  - Charges for Well-Baby Care
  - Routine Well-Woman Examinations
  - Immunizations
  - Injections received in a physician’s office

**Behavioral Health**
- Inpatient mental health treatment and drug and alcohol rehabilitation
- Outpatient mental health treatment and drug and alcohol rehabilitation
- Alcohol and drug rehabilitation centers

**Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders**
The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:
- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning. These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories.

Benefits include the following services provided on either an outpatient or Inpatient basis:
- diagnostic evaluations and assessment;
- treatment planning;
Benefits include the following services provided on an inpatient basis:

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

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

**Obesity Surgery**

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician when all of the following are true:

- you have a minimum Body Mass Index (BMI) of 40;
- you have documentation from a Physician of a diagnosis of morbid obesity of five years; and
- you are over the age of 21.

In addition to meeting the above criteria, the following must also be true:

- you have completed a 6-month Physician supervised weight loss program; and
- you have completed a pre-surgical psychological evaluation

**Other Services**

- Chiropractic expenses are reimbursed up to an annual maximum of 25 visits
- Hospice care for the terminally ill
- Home health care, up to a maximum of 60 visits total per calendar year
- Skilled Nursing Facilities, up to a maximum of 120 total days per calendar year
- Private duty nursing care given on an outpatient basis when provided by a licensed nurse
- Maternity-related medical services for prenatal care, postnatal care, delivery, and related complications, if any.

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

**Reproductive Resource Services (RRS)**

The Plan pays Benefits for infertility services provided under the Reproductive Resource Services program, as defined in Glossary. Reproductive Resource Services (RRS) provides education, counseling, infertility management and access to a national Network of premier infertility treatment clinics.

You will have access to a certain Network of facilities and Physicians participating in the Reproductive Resource Services program for infertility services. You must use a Reproductive Resource Service facility and provider in order to obtain benefits under the RRS program and pre-notification is required through Reproductive Resources Services Program (RRS). To enroll in the program and obtain information concerning infertility treatment, please contact Reproductive Resource Services at (866) 774-4626.

For infertility services and supplies to be considered Covered Health Services, you must contact Reproductive
Resource Services and speak with a nurse consultant prior to receiving services. All infertility treatment must be authorized by Reproductive Resource Services prior to receiving services in order to receive coverage.

Covered Health Services for infertility services and associated expenses include:

- Assisted Reproductive Technologies (ART): in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), Intra Cytoplasmic Sperm Injection (ICSI);
- insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI);
- embryo transportation related network disruption;
- artificial insemination;
- ovulation induction and controlled ovarian stimulation;
- pre-implantation genetic diagnosis (PGD) for diagnosis of genetic disorders only (with RRS medical director approval);
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm; and
- cryopreservation - embryo’s (storage is not included).

**Maternity Support Program**

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the toll-free number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- enrollment by an OB nurse;
- pre-conception health coaching;
- written and online educational resources covering a wide range of topics;
- first and second trimester risk screenings;
- identification and management of at- or high-risk conditions that may impact pregnancy;
- pre-delivery consultation;
- coordination with and referrals to other benefits and programs available under the medical plan;
- a phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more; and
- post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

**Neonatal Resource Services (NRS)**

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

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

You or a covered Dependent may also:

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

To receive NICU Benefits, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and Surgery - Outpatient.

- Birthing centers
- Up to $25,000 for the diagnosis and medically indicated treatment of infertility, up to a lifetime maximum of five attempts of any combination of the following Advanced Reproductive Technologies:
  - In-Vitro Fertilization
  - Gamete Intrafallopian Transfer
  - Zygote Intrafallopian Transfer
  - Embryo Transfer
  - Tubal Ovum Transfer
  - Artificial Insemination
  - Birth control including all oral contraceptives, injectables, and diaphragms through the retail and mail order prescription drug program

- Dental services when treatment is:
  - Necessary due to accidental damage
  - Received from a Doctor of Dental Surgery or Doctor of Medical Dentistry
  - Severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. Final treatment to repair the damage must be started within 3 months of the accident and completed within 12 months of the accident.

- Temporomandibular Joint Disorder (TMJ) will be covered with a lifetime maximum of $1,000

- Charges for acupuncture by a licensed acupuncturist

- Hearing aids and cochlear implants for dependent children when medically required as the result of a birth defect, accident or injury

- Physical therapy by a qualified, licensed therapist when prescribed by a doctor and necessary to restore body function lost or impaired because of a non-occupational injury, disease, or illness

- Charges for speech therapy to restore speech lost or impaired due to one of the following:
  - Surgery, radiation therapy, or other treatment which affects the vocal cords
  - Cerebral thrombosis (cerebral vascular accident)
  - Accidental injury which happens while covered under the plan

Charges for rental of a wheelchair, hospital-type bed, or other durable equipment for therapeutic treatment. Durable Medical Equipment must meet all of the following criteria:

- Ordered or provided by a physician for outpatient use
- Used for medical purposes
- Not consumable or disposable, except for ostomy supplies
Casts, splints, trusses, braces, crutches, artificial limbs, and artificial eyes — but not hearing aids, eyeglasses, or routine eye examinations

Durable Medical Equipment (DME)

- The Plan pays for Durable Medical Equipment (DME) that is:
  - ordered or provided by a Physician for outpatient use; used for medical purposes; not consumable or disposable; not of use to a person in the absence of a sickness, injury or disability; durable enough to withstand repeated use; and appropriate for use in the home. If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

- Examples of DME include but are not limited to:
  - equipment to administer oxygen; wheelchairs; hospital beds; delivery pumps for tube feedings; burn garments; insulin pumps and all related necessary supplies; insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment in this section.

- foot Orthotics (medical necessity required); braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces; and equipment for the treatment of chronic or acute respiratory failure or conditions; Braces that stabilize an injured body part and braces to treat curvature of the spine.

- The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME. Note: DME is different from prosthetic devices – see Prosthetic Devices in this section.

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

- At UHC’s discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person’s medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device.

Prescription Drug Benefits

Your medical coverage under Plan 1, Plan 2, and Plan 3 includes prescription drug benefits.

You may receive prescription drugs through retail pharmacies (up to 30-day supply) or through the mail order program (up to 90-day supply of maintenance drugs). Your copay amount will depend on:

- The medical option you choose
- Whether you have your prescription filled at a retail pharmacy or by mail order; and
- Whether you have your prescription filled using a Tier 1, Tier 2, or Tier 3 drug.

The list of Tier 1, Tier 2, and Tier 3 drugs is available when you log on to www.turnerbenefits.com and choose the link to the Medical-UHC website or by calling the number listed in your Benefit Provider Directory. It is updated four to six times during the year to reflect such changes as the release of new drugs, the expiration of drug patents, and the availability of new generic drugs.

It is always up to you and your doctor to decide which drug is right for you, but you can generally save money when you choose a Tier 1 or Tier 2 drug over a Tier 3 drug.

Participating (In-Network) Retail Pharmacies

You may purchase up to a 30-day supply of a prescription drug. You may use a Participating Network Pharmacy even if an out-of-network provider wrote your prescription. You may request a list of participating pharmacies when you log on to www.turnerbenefits.com and choose the link to the Medical-UHC website or by calling the number listed in your Benefit Provider Directory.
Out-of-Network Retail Pharmacies
If you have your prescription filled at an out-of-network pharmacy, you must pay the full cost at the time of purchase and file a claim for reimbursement. You will be reimbursed a percentage of the cost, based on your medical plan option.

Mail Order Program
You may purchase up to a 90-day supply of maintenance drugs through the mail order program. The mail order option is available to all plan participants and can save you additional money.

Mental Health and Substance Use Disorder
Expenses for Mental Health Services and Substance Use Disorder Services (alcohol and drug rehabilitation) are covered.

You must contact the Mental Health/Substance Use Disorder Administrator before receiving care. Call the toll-free number shown on your Medical ID card. If you are enrolled in an HMO, check your enrollment packet for a summary of Mental Health Services and Substance Use Disorder Services benefits for that plan.

Special Services
Transplant Services
Transplant services for the following organ and tissue transplants are covered when a physician orders the service, it is not an Experimental or Investigational Service or an Unproven Service, and is otherwise a covered expense. You must notify Personal Health Support for all transplant services. To receive in-network benefits, transplant services must be received at a Designated Network Facility (see page 27).

- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants are covered. If a separate charge is made for bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.
- Cornea transplants provided by a physician at a hospital. You are not required to receive cornea transplants at a Designated Network Facility in order to receive in-network benefits.
- Heart transplants
- Heart/lung transplants
- Lung transplants
- Kidney transplants
- Kidney/pancreas transplants
- Liver transplants
- Liver/small bowel transplants
- Pancreas transplants
- Small bowel transplants

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage. Specific guidelines must be followed to receive benefits for transplant services. Contact Personal Health Support at the number listed in your Benefit Provider Directory to receive these guidelines.

You may also be eligible for Transportation and Lodging benefits as shown below when expenses are in connection with Transplant Services received at a Designated Network Facility.

Cancer Resource Services
Personal Health Support will arrange for access to certain in-network providers participating in the Cancer Resource Services Program if you or your covered eligible dependent needs oncology services. You may be referred to the program by Personal Health Support, or you may self-refer by contacting Personal Health Support. The oncology services include covered health services and supplies rendered for the treatment of a condition that has a primary or
suspected diagnosis relating to cancer. In order to receive the highest level of benefits, you should contact Cancer Resource Services before you receive covered health services.

You will receive benefits under the program only when services are performed in a Cancer Resource Services facility after proper notification to the provider from Cancer Resource Services.

Cancer clinical trials and related treatment and services must be recommended and provided by a physician in a cancer center that participates in the Cancer Resource Services Program at the time the treatment or service is given.

You may also be eligible for Transportation and Lodging benefits as shown below when expenses are in connection with services received at a Cancer Resource Services program.

**Congenital Heart Disease Services**

Benefits are available for Congenital Heart Disease (CHD) services when the service is covered and not an Experimental or Investigational Service or an Unproven Service. You must notify Personal Health Support to receive CHD services, including outpatient diagnostic testing, in utero services and evaluation. CHD services include:

- Congenital heart disease surgical interventions
- Interventional cardiac catheterizations
- Fetal echocardiograms
- Approved fetal interventions

You may also be eligible for Transportation and Lodging benefits as shown below when expenses are in connection with CHD services received at a Congenital Heart Disease Resource Services program.

**Transportation and Lodging**

Personal Health Support will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging for the recipient of transplant services, cancer-related care, or CHD services and a companion are available under the plan as follows:

- Transportation of the patient and one companion traveling on the same day(s) to and/or from the site of the transplant procedure, cancer-related care, or CHD services for the purposes of an evaluation, the covered procedure, or necessary post-discharge follow-up.
- Eligible expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- Travel and lodging expenses are available only if the recipient of the transplant services, cancer-related care, or CHD services resides more than 50 miles from the Designated Network Facility.
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the $100 per diem rate.
- There is a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the recipient of transplant services or cancer-related care and companion(s) and reimbursed under the plan in connection with all cancer-related and/or transplant procedures.
- There is a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the CHD services recipient and companion(s) and reimbursed under the plan in connection with all CHD services.

You must notify Personal Health Support as soon as the possibility of a need for special services arises, and before a pre-service evaluation is performed at a designated center. If you do not notify Personal Health Support, your benefits will be reduced or denied.

**Expenses Not Covered**

The plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with the following:

- Expenses that exceed negotiated contract rates for in-network providers or HMO providers
- Expenses incurred with an out-of-network provider that do not meet the definition of Covered Health Services. Charges made by a hospital for confinement in a special area of the hospital that provides non-acute care, by whatever name called, including but not limited to the type of care given by the facilities listed below. If that type of facility is otherwise covered under this plan, then benefits for that covered facility that is part of a hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a hospital:
  - Adult or child day care center
  - Surgical Center
  - Half-way house
  - Hospice, except as specifically provided
  - Skilled nursing facility, except as specifically provided
  - Treatment center, except as specifically provided
  - Vocational rehabilitation center
  - Any other area of a hospital that renders services on an inpatient basis for other than acute care of sick, injured or pregnant persons

- Custodial Care made up of services and supplies that meet one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment
  - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health professional
  - Care that meets one of these conditions is Custodial Care regardless of any of the following:
    - Who recommends, provides, or directs the care
    - Where the care is provided
    - Whether or not the patient or another caregiver can be or is being trained to care for him or herself

- Education, training, and bed and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged, or a nursing home

- Private duty nursing services while confined in a facility

- Stand-by services required by a physician

- An organ or tissue transplant listed as a Qualified Procedure under the Transplant Benefit Program if Personal Health Support was not notified prior to receiving services

- Health services for organ tissue transplants, except as identified under Transplantation Services in Covered Expenses unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare’s transplant guidelines; determined by Personal Health Support not to be proved procedures for the involved diagnoses; and not consistent with the diagnosis of the condition.

- Expenses and associated expenses incurred for services and supplies for Experimental, Investigational or Unproven Services, treatments, devices and pharmacological regimens, except for services that are deemed to be, in the Plan Administrator’s judgment, covered transplant services. The fact that an Experimental, Investigational, or Unproven Service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not necessarily result in coverage

- Surrogate parenting

- Reversal of sterilization

- Fees or payment to a donor for sperm or ovum donations or for maintenance and/or storage of frozen embryos

- Sex-change surgery

- Abdominoplasties
• Breast reconstruction surgery (except as provided in connection with a mastectomy)
• Cosmetic or reconstructive surgery or treatment (This is surgery or treatment primarily to change appearance. It does not matter whether or not it is for psychological or emotional reasons.)
• Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services, or supplies given in connection with or related to the surgery
• Eye glasses, contact lenses, routine eye examinations, hearing aids (except hearing aids outlined under Eligible Expenses on page 161)
• Care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, implants or any treatment to improve the ability to chew or speak (See Covered Expenses on page 62 for limited coverage of Oral Surgery and medical services.)
• Routine foot care, including the cutting or removal of corns and calluses, nail trimming, cutting, or debriding, except when needed for severe systemic disease
• Hygienic and preventive maintenance foot care unless there is a localized illness, injury or symptom involving the foot
• Speech therapy for educational purposes
• Speech therapy to treat stuttering, stammering, or other articulation disorders
• Intensive behavioral therapy/applied behavioral analysis are Unproven Services and will not be covered for the treatment of autism spectrum disorders (i.e., autistic disorder, Asperger’s disorder, Rett syndrome, pervasive development disorder)
  Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from injury, sickness, stroke, cancer, autism spectrum disorders or a congenital anomaly, or is needed following the placement of a cochlear implant as identified under Rehabilitation Benefit. A congenital anomaly is a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

• Sensitivity training, educational training therapy, or treatment for an education requirement
• Alternative treatments including:
  - Acupressure
  - Aromatherapy
  - Hypnotism
  - Massage therapy
  - Rolfing
  - Naturopathy services
  - Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health
• Ecological or environmental medicine, diagnosis and/or treatment
• Herbal medicine, holistic or homeopathic care, including drugs
• Chelation therapy, except to treat heavy metal poisoning
• Membership costs for health clubs, weight loss clinics, and similar programs
• Nutritional counseling
• Weight reduction or control
• The following treatments for obesity; non-surgical treatment, even if for morbid obesity; and surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery Covered Expenses
• Special foods, food supplements, liquid diets, diet plans, or any related products unless required to treat a medical condition

• Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accident or medical injury), hair transplants, hair weaving, or any drug that is used in connection with baldness

• Services given by a pastoral counselor

• Personal convenience or comfort items including, but not limited to, such items as televisions, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, and hot tubs

• Telephone consultations

• Services given by volunteers or persons who do not normally charge for their services

• Services or supplies received before you or your dependents become covered under this plan

• Completion of claim forms or missed appointments

• Services, supplies, medical care, or treatment given by your spouse or the child, brother, sister, parent, or grandparent of either you or your spouse

• Services or supplies that are not necessary, including any confinement or treatment given in connection with a service or supply that is not necessary

• An illness or injury for which benefits are payable under any Workers' Compensation Law

• Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as covered services

• Services or supplies received as a result of war declared or undeclared, or international armed conflict

• Expenses for Medical Evacuation and Repatriation
  
  Health services provided in a foreign country, unless required as Emergency Health Services
How To Use Your Medical Benefits

To Receive Plan 1, Plan 2, or Plan 3 Benefits

**In-Network Benefits**

1. **Call any in-network provider— including specialists — to make an appointment.** Log on to www.turnetbenefits.com and then choose the link to Medical – UHC or contact United Healthcare. See your Benefit Provider Directory for information to contact United Healthcare.

2. **Present your ID card when you arrive for your appointment.** If your ID card is lost or stolen, ask the doctor’s office to call the program’s Member Services to verify your eligibility. You should then call Member Services to request a new card.

3. **Receive treatment from your in-network provider.**

4. **Pay the copay for each in-network doctor or specialist office visit.** The copay includes all diagnostic testing, lab work, X-rays, and minor surgery performed in the doctor’s office. There are no claim forms to file.

5. **Notify Personal Health Support before a hospital stay.** If you are going to be admitted to the hospital, you or your provider must contact Personal Health Support before entering the hospital. You are subject to a $250 penalty if you do not contact Personal Health Support before a hospital admission and benefits may be reduced or denied (see page 155).

6. **Notify Personal Health Support before receiving certain outpatient procedures and services.** You or your provider must contact Personal Health Support if you or your covered dependent(s) are scheduled to receive an outpatient procedure or service that requires such notification. You are subject to a $250 penalty if you do not notify Personal Health Support before receiving these outpatient procedures and benefits may be reduced or denied (see page 155).

7. **Go to the nearest emergency room in a medical Emergency.** If you are admitted as an inpatient as a result of the Emergency, you or your representative must contact Personal Health Support within 2 business days or on the same day of admission, if reasonably possible, or your benefits may be reduced. If you have been admitted to an out-of-network hospital, you may be required to transfer to an in-network hospital as soon as it is medically appropriate to do so.

8. **If applicable, supply United Healthcare with any documents that would help the plan recover payment from a third party.** The plan has the right to recover payment when a third party is found to be responsible for medical expenses covered under the Medical Plan. For example, you could be in an automobile accident caused by another person and the courts could find that person responsible for your medical expenses (see page 190).

**Out-of-Network Benefits**

1. **Receive treatment from any provider.** Generally, the doctor will arrange any needed tests or hospitalization.

2. **Pay the full cost of the office visit, if required.** The plan pays a percentage of eligible expenses after you pay the annual deductible. You are responsible for any expense in excess of the eligible expenses amount.

3. **Notify Personal Health Support before a hospital stay.** If you are going to be admitted to the hospital by an out-of-network provider, you or your provider must contact Personal Health Support before entering the hospital. You must call within 2 business days, or on the same day of admission, if reasonably possible. You will pay a penalty if you do not contact Personal Health Support before an out-of-network hospital admission (see page 155).

4. **Notify Personal Health Support before receiving certain outpatient procedures and services.** You or your out-of-network provider must contact Personal Health Support if you or your covered dependents are scheduled to receive an outpatient procedure or service that requires such notification. You are subject to a $250 penalty if you do not notify Personal Health Support before receiving these outpatient procedures and benefits may be reduced or denied (see page 155).

5. **Go to the nearest emergency room in a medical Emergency.** If you are admitted as an inpatient as a result of the Emergency, you or your representative must contact Personal Health Support within 2 business days or on the same day of admission, if reasonably possible, or your benefits may be reduced. If you have
been admitted to an out-of-network hospital, you may be required to transfer to an in-network hospital as soon as it is medically appropriate to do so.

6. **File a claim with United Healthcare.** You can obtain medical claim forms by visiting [www.turnerbenefits.com](http://www.turnerbenefits.com) and choosing the link to the Medical-UHC website. Complete and submit the claim form along with an itemized bill from your physician or other supporting documentation. The itemized bill must show the patient’s name, employee’s name, doctor’s name, the date each expense was incurred and the type and nature of service rendered. Mail the claim directly to the United Healthcare address listed on your claim form.

7. **Receive appropriate reimbursement for your eligible expenses.** You must reach your annual deductible before you are eligible for reimbursement.

8. **Call United Healthcare if you have a question regarding a claim.** When you submit a claim for out-of-network care, benefits are automatically paid to you unless you authorize direct payment to your physician. If your claim is denied, you have the right to appeal. See page 181 for information regarding appeals.

   If applicable, supply United Healthcare with any documents that would help the plan recover payment from a third party. The plan has the right to recover payment when a third party is found to be responsible for medical expenses covered under the Medical Plan. For example, you could be in an automobile accident caused by another person and the courts could find that person responsible for your medical expenses (see page 190).

**Filing Claims**

1. **Obtain a claim form by visiting [www.turnerbenefits.com](http://www.turnerbenefits.com) and choosing the link to the Medical-UHC website or by contacting the Benefits Service Center.**

2. **Complete all applicable sections of the claim form.**

3. **Submit your claim form to your primary plan first and then to any secondary plan you may have.** (See page 170 for information on primary and secondary plans.) You must file your claim within 12 months after the date of service. Otherwise, benefits will be reduced as determined by UHC. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

4. **Send your completed form with original bills and receipts to United Healthcare.** Submit the claim form along with an itemized bill from your physician or other supporting documentation. The itemized bill must show the patient’s name, employee’s name, doctor’s name, the date each expense was incurred and the type and nature of service rendered. Mail the claim directly to the United Healthcare address listed on your claim form.

**What Else You Should Know**

**Medical Plan Enrollment**

You have the opportunity to enroll yourself and your dependents in Retiree Medical Coverage when you retire. You may make changes each year during Open Enrollment.

If you do not elect coverage at the time you retire — or if you discontinue coverage any time after you retire— you will not be able to re-enroll in medical coverage at a later date.

Generally, once you choose your medical coverage, you may not change your coverage until the next Open Enrollment period, unless you meet one of the limited exceptions described on pages 4-6.

For more information about eligibility and enrollment, see Your Benefits Program, beginning on page 1.

**Removing Dependents from Medical Coverage**

It is your responsibility to contact the Benefits Service Center to remove ineligible dependents from coverage within 30 days from the date the dependent becomes ineligible. Until you do so, you will continue to pay for coverage, even if the plan cancels coverage for that dependent. Cancellation is effective at the end of the month during which he or she becomes ineligible. No refunds will be made for premiums paid for an ineligible dependent if you did not notify the Benefits Service Center within 30 days of the date the dependent became ineligible.
When Retiree Medical Coverage Begins

Your retiree coverage begins on the date you become eligible for coverage if you enroll during your initial enrollment period. Your eligible dependents’ coverage becomes effective on the same date, if you have enrolled them during your initial enrollment period.

Nurse Line

With this nurse telephone program, reliable medical information is just a phone call away. Highly trained registered nurses are available 24 hours a day to assist you. These nurses work as your advocate and help you understand your medical problem and plan possible questions for your physician. They can also help you in an emergency situation, or help you determine whether a situation is an Emergency or not.

For example, if you have a major illness, you can work with a nurse to consider treatment options and understand the drugs that have been prescribed. Or, if you prefer, the nurse can send you materials and information on your illness or injury. You can access the Nurse Line through the Turner Benefits Service Center at the number listed in your Benefit Provider Directory.

Cost for Medical Coverage

You share the cost for the Early Retiree Medical Program with Turner. Each year, you will be provided with information on your costs for the following Plan Year. Your costs are based, in part, on your years of service. For more information on how your actual premiums rates are determined, please contact the benefits center.

Coordination of Benefits

If you or your dependents also have coverage under another medical plan (such as your spouse’s), benefits are coordinated between the two plans to avoid duplication of payment. Through the coordination of benefits, you will not receive more than 100% of the allowable expenses incurred during a calendar year by combining benefits from the Medical Plan and your other group coverage.

The Turner Medical Plan will not coordinate benefits with school accident coverage or supplemental hospital indemnity benefit plans. It will coordinate benefits with the following types of medical and health care benefits:

- No-fault motor vehicle plans or other types of plans required by law. This refers to a motor vehicle plan that is required by law and provides medical care payments that are made, in whole or in part, without regard to fault. A person subject to such law who has not complied with the law will be deemed to have received the benefits required by law
- Group or group-type health care or medical plans (including other company plans)
- Any coverage under labor-management trustee plans, union welfare plans, employer organization plans or employee benefit organization plans
- Any coverage under governmental plans, such as Medicare. This does not include a state plan under Medicaid or any governmental plan when, by law, its benefits are secondary to those of any private coverage non-governmental program
- Any private or association policy or plan of medical or medical expense reimbursement, which is rated for group or individual
- Preferred Provider Organizations (PPO or any combination of this type of managed care.

With coordination of benefits, the primary plan pays your benefits first. Then the secondary plan pays any additional benefit that may be due. The following guidelines are used to determine which plan is primary:

- A plan that does not contain a coordination of benefits provision will pay before this plan
- The plan covering the patient as an employee will be primary
- A no-fault motor vehicle plan (or another type of plan required by law) will be primary to this plan
- For a dependent child, if both parents have group medical plans, the parent whose month and day of birth comes first during the calendar year will have the primary plan. This is called the “birthday rule.” If both parents have the same birthday, the plan that covered one parent for a longer period will be primary
• For a dependent child of parents who are divorced or separated, the plan of the parent with custody of the dependent child usually pays benefits for the child first. If the parent with custody remarries, the stepparent’s plan pays second, and the plan of the natural parent without custody pays third. If a court decree places financial responsibility for the dependent child’s medical care on one parent, that parent’s plan always pays first.

If none of the above situations apply, the plan covering the person the longer time pays first, except when both plans provide that plan covering a person as an employee always pays before a plan covering that person as a laid-off employee or retiree. In this case, the plan covering the active employee pays first. If the other plan does not have a provision regarding retired or laid-off employees, this exception does not apply.

In order to administer claims, the provider as the right to:

• Provide or receive information needed to determine benefits
• Recover money paid above the amount required under the coordination of benefits rules
• Pay the administrator of another plan the amount that would have been paid by this plan. This amount will be considered a benefit under this plan.

As a retiree, if you are eligible for Medicare, Medicare will always be considered the primary plan.

When the Medical Plan May Recover Payment

The Medical Plan is entitled to be repaid for any medical expenses paid under the plan if a third party, such as another person or insurance company, can be held legally responsible for your medical expenses. This could happen, for example, in an automobile accident.

In such a situation, the Medical Plan has the right to take any actions necessary to enforce its rights to be reimbursed. See page 190 for more information.

Medical Child Support Order

A Medical Child Support Order (MCSO) is an order or judgment from a state court — served on the company or the agent for service of legal process — directing the Plan Administrator to cover a child for benefits under the health care plans. To qualify as a MCSO, it must:

• State the name and last known mailing address of the employee and each child covered by the order
• Give a reasonable description of the type of coverage or benefits the plan must provide for each covered child
• Specify the period of time to which the order applies
• Clearly identify each plan to which the order applies

A MCSO does not require the plan to provide a benefit or form of benefit — standard or optional — that is not otherwise provided for under the plan as of the effective date of the order.

When the company receives a MCSO, the employee and each child covered is notified of the order’s receipt, the procedure used to determine if the MCSO is qualified and whether or not it qualifies. The Plan Administrator will add dependents and adjust contributions as required to comply with a qualified MCSO.

When Medical Coverage Ends

All coverage under the Medical Plan ends at the end of the calendar month in which:

• You withdraw from the plan
• You or your qualified beneficiaries fail to make required contributions

No benefits will be payable once your coverage ends, even if you are receiving an ongoing course of treatment.

At the time of termination of coverage, you will be furnished with a certification of prior health coverage statement that will indicate the type of coverage you had and the effective date(s) of coverage. If you become eligible for coverage under the new group health care plan that has a preexisting condition clause, you may need to provide this certification of prior health coverage to reduce the pre-existing condition exclusion period.
Survivor Benefits

If you die while covered under the plan, your surviving spouse or Registered Domestic Partner will remain eligible for coverage during his or her lifetime. Your dependent children will remain eligible as long as they meet the definition of eligible dependent children (see pages 3-4).

Conversion Privilege

The Turner Medical Plan cannot be converted to an individual policy.