

MEMBER HANDBOOK

**For your
Medical and Dental Benefits**

Effective January 1, 2010

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GENERAL INFORMATION ABOUT YOUR HEALTH PLAN

Welcome to your Health Plan. We hope that this member handbook will help you in utilizing your benefits. This handbook and the summary of benefits that you have received are just a summary of the plan. They are not a contract. ***Refer to the Master Group Policy (available from your employer) for a complete description of your Health Plan.***

If you have any questions regarding your medical or dental benefits, please call the P5 Health Customer Service at 1-888-533-3405 option 1. Customer Service Representatives are available Monday through Friday from 7:00 a.m. to 6:00 p.m. MST to assist you with claims, eligibility, benefits, or other questions that you have regarding your Health Plan.

PLEASE HAVE YOUR PROVIDERS SEND CLAIMS TO:

***P5 Health Plan Solutions
P.O. Box 9554
Salt Lake City, UT 84109***

For our Medical Plan we use the following Network of Providers:

- Idaho Physicians Network for Idaho Employees
- Beechstreet for Employees in all other states
- Employees in remote areas are on the out-of-area plan. No network is designated, but they do have access to Beechstreet providers

Please refer to your ID Card for Network clarification. To access provider information log in to your account at www.p5health.com. Click on benefits. Then click on Find Provider Network on the right-hand side. Both Beechstreet and IPN Networks can be accessed here so make sure to choose the appropriate one for your plan. The provider website is subject to change at any time and is updated on a monthly basis.

For our Dental Plan we DO NOT use a specific network of Dental Providers. Under the Dental plan you have the freedom to choose the Dentist you want to use.

If any changes are made to your plan outside of open enrollment, you will be notified in writing before the effective date of that change.

MEDICAL BENEFITS SUMMARY – 500 Deductible Plan

Maximum Lifetime Benefit Amount: \$2,000,000.00

	Your Responsibility to Network Providers	Your Responsibility to Out-of- Network Providers
DEDUCTIBLE PER CALENDAR YEAR (Note In-network and Out-of-Network Deductibles are separate and do not accumulate towards each other)		
Per Person	\$500	\$1,000
Per Family	\$1,000	\$2,000
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR		
Per Person	\$3,000	\$5,000
Per Family	\$6,000	\$10,000
The plan will pay 100% of the covered charges after a member has reached the outlined Maximum out-of-pocket, unless stated otherwise.		
The following do not apply towards the out-of-pocket maximum and are never paid at 100%:		
Deductibles	Hospice Care	Cost Containment Penalties
Copayments	Prescription Drug Copayments	
Prosthetics & Orthotics	Durable Medical Equipment	
COPAYMENTS		
Primary Care Physician Office Visit	\$15 copay	Deductible, then 40% of UCR
Specialist Office Visit	\$20 copay	Deductible, then 40% of UCR
Other services in Specialists Office	10% coinsurance	Deductible, then 40% of UCR
Emergency Room	\$100 copay, then 20% (Must be Medically Necessary or will not be covered)	\$100 copay then 20% (Must be Medically Necessary or will not be covered)
Urgent Care Center	\$30 copay	\$50 copay
Please note: the Emergency Room copay will be waived if the patient is admitted to the Hospital. If admitted to the Hospital from the Emergency Room, the Health Plan must be notified within 72 hours of the admission for authorization.		
COVERED SERVICES		
Hospital Services		
Room and Board	Deductible, then 20%	Deductible, then 40% of UCR
Intensive Care	Deductible, then 20%	Deductible, then 40% of UCR
Skilled Nursing Facility (30-day Maximum stay per Calendar year)	Deductible, then 20%	Deductible, then 40% of UCR
Organ Transplants	Deductible, then 20%	Deductible, then 40% of UCR
Outpatient Services		
Outpatient Surgery (including lab & pathology)	Deductible, then 20%	Deductible, then 40% of UCR
X-ray and Diagnostic Testing (including MRI's, non-routine mammogram and colonoscopy)	Deductible, then 20%	Deductible, then 40% of UCR
Ultrasound	Deductible, then 20%	Deductible, then 40% of UCR
Impacted Wisdom Teeth	Deductible, then 20%	Deductible, then 20%
Stand-alone Laboratory or Pathology Services	Covered at 100%	Covered at 100%
Physician Services		
Inpatient Visits	Deductible, then 20%	Deductible, then 40% of UCR

Primary Care Office Visit	\$15 copay	Deductible, then 40% of UCR
Specialist Office Visit	\$20 copay	Deductible, then 40% of UCR
Other services in Specialists Office	10% coinsurance	Deductible, then 40% of UCR
Allergy Office Visits	\$20 copay	Deductible, then 40% of UCR
Allergy Treatments	\$5 copay	Deductible, then 40% of UCR
Emergency Room Physician (when Medically Necessary)	20% coinsurance after ER Copay	20% coinsurance after ER Copay
Surgery, X-ray, and Diagnostic Testing	Deductible, then 20%	Deductible, then 40% of UCR
Office or Stand-alone Laboratory or Pathology	Covered at 100%	Covered at 100%
Miscellaneous Services		
Home Health Care (60-day maximum per Calendar Year)	Deductible, then 20%	Deductible, then 40% of UCR
Hospice Care (\$8,000 Lifetime maximum)	Deductible, then 20%	Deductible, then 40% of UCR
Infertility Treatment	Covered at 50%. Calendar year Maximum of \$1,500, Lifetime Max. of \$5,000	Deductible then 50% of UCR. Calendar year Max. of \$1,500, Lifetime Max. of \$5,000
Ambulance Services	Deductible, then 20%	Deductible, then 20%
Occupational, Physical, and Speech Therapy	\$15 copay \$5 copay for Mountain Land Provider	Deductible, then 40% of UCR
Durable Medical Equipment Prosthetics / Orthotics	Covered at 50%. Combined Calendar year Maximum of \$2,000	Deductible, then 50%. Combined Calendar year Maximum of \$2,000
Adoption Benefit	\$2,500 per adoption, No Deductible	
Preventive Care Services		
Routine Well Adult Care	\$15 copay	Deductible, then 40% of UCR
Routine Well Care includes: office visits, pap smear, preventive mammogram, prostate screening, preventive colonoscopy, gynecological exam, routine physicals, adult immunizations and laboratory blood tests.		
Frequency limits for Mammogram	Age 35 through 39: Single Baseline Mammogram Ages 40 through 49: Every 2 years Ages 50+: Annually	Same frequency limits, but covered Deductible, then 40% of UCR
Inpatient Newborn Care	20% coinsurance	Deductible, then 40% of UCR
Routine Well Child Care	\$15 copay	Deductible, then 40% of UCR
Pregnancy	\$15 copay for office visits, Deductible, then 20% for all other services	Deductible, then 40% of UCR
Ultrasound for Pregnancy	Covered at 80%	
Smoking Cessation	Reimbursement up to \$150	for smoking cessation
Weight Management	Reimbursement up to \$200	for weight loss centers & programs
Mental Health Disorders		
Inpatient Services	Deductible, then 20%	Deductible, then 40% of UCR
Partial Hospitalization	Deductible, then 20%	Deductible, then 40% of UCR
Office Visits	\$30 copay	Deductible, then 40% of UCR

Substance Abuse Treatment		
Inpatient Services	Deductible, then 20%	Deductible then 40% of UCR
Outpatient Services	Deductible, then 20%	Deductible then 40% of UCR
Residential Treatment Centers	Not Covered	Not Covered
Vision Services		
Routine Eye Exam	\$15 copay	Deductible, then 40% of UCR
Other Unlisted Covered Medical Services	Deductible, then 20%	Deductible, then 40% of UCR

MEDICAL BENEFITS SUMMARY – 1,000 Deductible Plan

Maximum Lifetime Benefit Amount: \$2,000,000.00

	Your Responsibility to Network Providers	Your Responsibility to Out-of- Network Providers
DEDUCTIBLE PER CALENDAR YEAR (Note In-network and Out-of-Network Deductibles are separate and do not accumulate towards each other)		
Per Person	\$1,000	\$2,000
Per Family	\$2,000	\$4,000
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR		
Per Person	\$4,000	\$8,000
Per Family	\$8,000	\$16,000
The plan will pay 100% of the covered charges after a member has reached the outlined Maximum out-of-pocket, unless stated otherwise.		
The following do not apply towards the out-of-pocket maximum and are never paid at 100%:		
Deductibles	Hospice Care	Cost Containment Penalties
Copayments	Prescription Drug Copayments	
Prosthetics & Orthotics	Durable Medical Equipment	
COPAYMENTS		
Primary Care Physician Office Visit	\$20 copay	Deductible, then 40% of UCR
Specialist Office Visit	\$25 copay	Deductible, then 40% of UCR
Other services in Specialists Office	10% coinsurance	Deductible, then 40% of UCR
Emergency Room	\$125 copay, then 20% (Must be Medically Necessary or will not be covered)	\$125 copay, then 20% (Must be Medically Necessary or will not be covered)
Urgent Care Center	\$35 copay	\$70 copay
Please note: the Emergency Room copay will be waived if the patient is admitted to the Hospital. If admitted to the Hospital from the Emergency Room, the Health Plan must be notified within 72 hours of the admission for authorization.		
COVERED SERVICES		
Hospital Services		
Room and Board	Deductible, then 20%	Deductible, then 40% of UCR
Intensive Care	Deductible, then 20%	Deductible, then 40% of UCR
Skilled Nursing Facility (30-day Maximum stay per Calendar year)	Deductible, then 20%	Deductible, then 40% of UCR
Organ Transplants	Deductible, then 20%	Deductible, then 40% of UCR
Outpatient Services		
Outpatient Surgery (including lab & pathology)	Deductible, then 20%	Deductible, then 40% of UCR
X-ray and Diagnostic Testing (including MRI's, non-routine mammogram and colonoscopy)	Deductible, then 20%	Deductible, then 40% of UCR
Ultrasound	Deductible, then 20%	Deductible, then 40% of UCR
Impacted Wisdom Teeth	Deductible, then 20%	Deductible, then 20%
Stand-alone Laboratory or Pathology Services	Covered at 100%	Covered at 100%
Physician Services		
Inpatient Visits	Deductible, then 20%	Deductible, then 40% of UCR

Primary Care Office Visit	\$20 copay	Deductible, then 40% of UCR
Specialist Office Visit	\$25 copay	Deductible, then 40% of UCR
Other services in Specialists Office	10% coinsurance	Deductible, then 40% of UCR
Allergy Office Visits	\$25 copay	Deductible, then 40% of UCR
Allergy Treatments	\$10 copay	Deductible, then 40% of UCR
Emergency Room Physician (when Medically Necessary)	20% coinsurance after ER Copay	20% coinsurance after ER Copay
Surgery, X-ray, and Diagnostic Testing	Deductible, then 20%	Deductible, then 40% of UCR
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Ambulance Services	Deductible, then 20%	Deductible, then 20%
Occupational, Physical, and Speech Therapy	\$20 copay \$10 copay for Mountain Land Provider	Deductible, then 40% of UCR
Durable Medical Equipment Prosthetics / Orthotics	Covered at 50%. Combined Calendar year Maximum of \$2,000	Deductible, then 50%. Combined Calendar year Maximum of \$2,000
Adoption Benefit	\$2,500 per adoption, No Deductible	
Preventive Care Services		
Routine Well Adult Care	\$20 copay	Deductible, then 40% of UCR
Routine Well Care includes: office visits, pap smear, preventive mammogram, prostate screening, preventive colonoscopy, gynecological exam, routine physicals, adult immunizations and laboratory blood tests.		
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Routine Well Child Care	\$20 copay	Deductible, then 40% of UCR
Pregnancy	\$20 copay for office visits, Deductible, then 20% for all other services	Deductible, then 40% of UCR
Ultrasound for Pregnancy	Covered at 80%	
Smoking Cessation	Reimbursement up to \$150	for smoking cessation
Weight Management	Reimbursement up to \$200	for weight loss centers & programs
Mental Health Disorders		
Inpatient Services	Deductible, then 20%	Deductible, then 40% of UCR
Partial Hospitalization	Deductible then 20%	Deductible, then 40% of UCR
Office Visits	\$30 copay	Deductible, then 40% of UCR

Substance Abuse Treatment		
Inpatient Services	Deductible, then 20%	Deductible, then 40%
Outpatient Services	Deductible, then 20%	Deductible, then 40%
Residential Treatment Centers	Not Covered	Not Covered
Vision Services		
Routine Eye Exam	\$20 copay	Deductible, then 40% of UCR
Other Unlisted Covered Medical Services	Deductible, then 20%	Deductible, then 40% of UCR

Prescription Drug Benefit

At a Participating Pharmacy (for a 30-day supply)

For Generic Drugs \$10 copay

For Brand Name Drugs 25% for Preferred formulary, 50% for Non-formulary

Through Mail Order (for a 90-day supply)

For Generic Drugs \$20 copay

For Brand Name Drugs 25% for Preferred formulary, 50% for Non-formulary

USING YOUR HEALTH PLAN

Helpful Hints:

- Carry your ID Card and give it to your provider at each visit.
- Make sure to use Physicians, Facilities and other Providers that are In-network.
- Make sure that procedures requiring prior authorization are approved through the Health Plan before getting the service or your benefits may be reduced.
- When you receive a laboratory or pathology bill at your home, please contact the company and give them your insurance information so they will bill the Health Plan.

Primary Care Physician:

You do not need to designate a Primary Care Physician. Using an In-network provider will provide you with the highest level of benefits from your plan. A Primary Care Physician can be a Family or General Practice, Internal Medicine, OB/GYN, or a Pediatric Physician.

Specialists and Outpatient Therapy:

Our plan **does not** require a physician's referral to receive services from a Specialist or an Occupational, Physical or Speech Therapist. Using an In-network provider will provide you with the highest level of benefits from your plan.

Prior-Authorizations:

Prior-Authorization is required before certain services can be received. Your Provider must contact the **Utilization Management Department at 1-888-533-3405 Option #2**. Approval must be obtained prior to services being rendered. The following services require prior-authorization. This list is **not** intended to be all inclusive:

- All Inpatient Facility Admissions; except Maternity
- Inpatient Admissions from an Emergency Room
- Behavioral Health Services – including evaluation and service, substance abuse, detoxification programs/services, neuro-psychiatric testing
- Diabetic Counseling
- Genetic Counseling – evaluation
- Transportation – all non-urgent forms
- Cardiopulmonary Rehabilitation Therapy
- Home Infusion
- Pain Management
- Sleep Studies
- Injections Costing more than \$500

Out-of-Network Services:

Your plan has an out-of-network option and you can use this to get payment for services provided by a non-contracted provider. There is a higher out-of-network deductible that applies and higher coinsurance percentage that will be applied once the out-of-network deductible is met. Prior-authorization rules still apply to get benefits paid. Please refer to the appropriate **MEDICAL BENEFITS SUMMARY** at the beginning of this document.

When using a provider who is not contracted with our network, a member may be billed for any amounts in excess of what is allowed under the plan. This means if there is a difference between the usual, reasonable and customary charges (UCR) that the Health Plan pays and what the Provider billed, the Provider may require the member to pay the difference in addition to their portion of the benefit. This occurs because non-contracted providers do not have negotiated rates with the Health Plan.

URGENT AND EMERGENCY SITUATIONS

Service Area:

Unless it is an emergency, you must use participating providers and facilities within your service area. Your Health Plan has a service area that is within a 40-mile radius of your employment.

Urgent Care or After Hours Facilities:

If you have an urgent medical need which is **not life threatening**, please contact your physician first. If your physician is unavailable or can not refer you to someone else, you can pick another physician from the website or visit a designated Urgent Care Center if there is one in your area.

An **urgent care situation** is defined as an acute health condition with a sudden or unexpected onset, that is **not life threatening**, but does pose a danger to the health of the member if a physician is not seen within 24 hours.

While traveling **outside of the service area** on business or pleasure, services for urgent conditions handled by non-participating providers will be covered as In-network benefits. All others will be treated as an out-of-network benefit.

Emergency Room Visits:

If you are experiencing a life-threatening emergency (which is real or perceived), go to the nearest facility or call an ambulance. An emergency is defined as medically necessary services for the sudden or unexpected onset of a condition requiring immediate medical or surgical care to prevent death, serious disability, or permanent damage to the member's health. Life threatening emergencies can include: heart attack symptoms, serous breathing difficulties, spinal injuries, uncontrollable bleeding, major burns, shock, or unconsciousness.

***Please request that the Emergency Room notes are submitted to the Health Plan with your claim. Each Emergency Room Visit will be reviewed by the Health Plan for Medical Necessity. If your visit to the Emergency Room is determined **not to be Medical Necessary, your claim may be denied.** Keep a copy for your records.

If you are admitted to the hospital from an Emergency Room Visit, remember that you will need to contact the Health Plan within 72 hours for authorization or they will reduce your benefits by 50%.

Emergency Transportation:

In an emergency situation you should get yourself to the nearest facility or call 911 for immediate assistance. If an air ambulance is needed, it will be covered for services when an ambulance is not available or appropriate, or the delay would jeopardize the patient's safety. Requests for non-emergency transportation will not be covered by the Health Plan unless prior-authorization is received.

MEDICAL BENEFITS

This benefit applies when covered charges are incurred by a person while covered under this Plan.

DEDUCTIBLE:

Deductible Amount. Amount of medical charges for which no benefits will be paid for certain services. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. The dollar amount shown in the Schedule of Benefits incurred by members of a Family Unit toward their Calendar Year deductibles.

BENEFIT PAYMENT:

Each Calendar Year benefits will be paid for a Covered Person for the medical charges in excess of the deductible and any copayments. Payment will be made at the rate shown in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

OUT-OF-POCKET LIMIT:

Amount of out-of-pocket coinsurance that an individual or family unit is responsible for in a given year. Once this maximum is reached, the plan will pay 100% of the charges (except for excluded charges, copays and rx) for the remainder of that year.

PRESCRIPTION DRUG COVERAGE

Prescriptions:

You can get your drug prescriptions filled for 30 days by using your ID card at a Participating Pharmacy.

The member is responsible for paying their portion of the cost directly to the Pharmacy. Your Health Plan uses a Preferred list of Drugs called a "Formulary". This list identifies the Preferred drugs by generic and brand. Generic drugs will be the most cost effective option. Drugs that are not on the Preferred list are called non-formulary and may still be available for a higher cost as long as they are not listed as a plan exclusion. Prescription Drug costs will not be applied towards your deductible or out-of-pocket maximum.

Mail Order Program:

Your plan offers a mail order program. This plan allows you to obtain prescription drugs at a cost savings to you and is conveniently delivered to your home. You may get your maintenance drugs (drugs that you take on a regular basis) through the mail order program for up to a 90-day supply. You can obtain mail order forms and information from your Human Resource Department or directly from P5Health.

Prescription Drug Exclusions:

- Administration of a drug
- Allergy desensitization products
- Appetite suppressants
- Consumed on the premises
- Devices
- Experimental drugs
- FDA, any drug not approved by the FDA
- Immunizations
- Implantable drugs and devices, including, drug infusion pumps and release devices
- Infertility drugs
- Injectable drugs, except for insulin
- Investigational drugs
- Medically excluded drugs per Plan Document
- No charge drugs
- No prescription, any drug that can legally be bought without a prescription
- Refills, any refill more than one year after prescription was written or that is more than the number of refills ordered by the physician
- Smoking cessation aids (May be reimbursable under the Wellness Program)
- Vitamins, except pre-natal

EXCLUSIONS UNDER YOUR HEALTH PLAN

What are the exclusions of this Health Plan?

Charges for the following services and supplies are excluded from coverage under the Health Plan. (Note: Hospital and other charges related to or as a follow-up to services and supplies that are specified as excluded or beyond the limitations shown in this Plan Document are likewise excluded):

1. Acupuncture
2. Abortion; unless the life of the mother is endangered by the birth of the child
3. Biofeedback
4. Blood, blood plasma and blood products
5. Copying or transferring of medical records
6. Complications of non-covered treatments
7. Cosmetic services and supplies, except re-constructive surgery that is determined to be Medically Necessary to repair a significant functional disorder as a result of illness or injury, or incident to a Medically Necessary mastectomy
8. Custodial care. Services or supplies provided mainly as rest cure, maintenance, or custodial
9. Educational or vocational testing and treatment
10. Excess charges. The part of the expense that is in excess of the Usual and Reasonable Charge
11. Exercise programs. (May be reimbursable under the Wellness Program)
12. Experimental or non-Medically Necessary Services
13. Eye glasses, contact lenses, orthopedic eye care, and radial keratotomy or other eye surgery to correct near sightedness
14. Foreign Travel for routine services. Meaning routine care is not covered outside of the service area
15. Government Coverage. Care, treatment or supplies from a government funded program or agency
16. Hair loss care or treatment
17. Hearing aids and exams
18. Hospital Employees
19. Illegal Acts. Charges for services received as a result or injury or sickness caused by or contributed to by engaging in an illegal act or occupation
20. No charge services. Meaning services that have not charge associated with them

21. Non-emergency Hospital Admissions. Care and treatment billed by a Hospital for non-medical emergencies on a Friday or a Saturday
22. No obligation to pay. Charges incurred for which Plan has no legal obligation to pay
23. No Physician recommendation
24. Not otherwise specified as covered
25. Obesity care and treatment. Condition related to morbid obesity may be considered
26. Occupational. Care and treatment of an injury or sickness that is occupational
27. Paternity testing
28. Personal Comfort items
29. Plan design excludes. Charges excluded by the plan design as mentioned in Plan Document
30. Private Duty Nursing
31. Rehabilitation services related to the treatment of chemical dependency
32. Relative giving services. Meaning care or treatment from a related family member
33. Replacement of braces unless there is sufficient change in the member's physical condition to make the original device no longer functional
34. Routine Care. Charges for routine or periodic examinations which are not directly related to the diagnosis of a specific injury or sickness
35. Services before or after coverage was effective under the plan
36. Sex Changes
37. Sleep disorders, unless deemed Medically Necessary
38. Smoking cessation. (May be reimbursable under the Wellness Program)
39. Spinal Manipulation Services. Chiropractic Care
40. Surgical Sterilization reversal
41. Travel or accommodations
42. War. Any loss that is due to declared or undeclared war

DENTAL SCHEDULE OF BENEFITS

This Section applies, if you have chosen to receive Dental Benefits. Limitations may apply, See Dental Section)

Calendar Year Deductible:

Per Person	\$50.00
Per Family Unit	\$150.00

The deductible is waived for Preventive – Class A Services

Dental Percentage Payable:

Class A Services – Preventive 100% of Billed Charges

Class B Services - Basic 80% of UCR

Class C Services - Major 50% of UCR

Class D Services - Orthodontia 50% of UCR

(No benefits are payable for Class D in the first 12 months of coverage. Orthodontia is available to both Children and Adults)

Maximum Benefit Amount:

For Classes A, B, & C:

Calendar Year Maximum per Person \$1,200

For Class D-Orthodontia:

Lifetime maximum per Person \$1,500

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

DEDUCTIBLE:

Deductible Amount. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT:

Each Calendar Year benefits will be paid for a Covered Person for the dental charges in excess of the deductible. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT:

The Maximum Dental Benefit Amount is shown in the Schedule of Benefits.

DENTAL CHARGES:

Dental charges are the Usual and Reasonable Charges (UCR) made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will allocate the overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services: Preventive and Diagnostic Dental Procedures

The limits on Class A Services are for routine services.

- (1) Routine oral exams. Includes the cleaning and scaling of teeth. Limit of two exams per Covered Person every Calendar Year
- (2) Two bitewing x-ray series every twelve months
- (3) One full mouth x-ray every five Calendar Years
- (4) One panoramic x-ray every two Calendar Years
- (5) Two fluoride treatments every twelve months for covered Dependents under nineteen
- (6) Space maintainers for covered Dependents under nineteen replacing primary teeth
- (7) Sealants for covered Dependent children under the age of fourteen
- (8) Emergency palliative treatment for pain

Class B Services: Basic Dental Procedures

- (1) Dental x-rays not included in Class A
- (2) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch. ***Oral Surgery for impacted teeth is covered under the medical outpatient benefits***
- (3) Periodontics (gum treatments)
- (4) Endodontics (root canals)
- (5) Extractions. This service includes local anesthesia and routine post-operative care
- (6) Fillings, other than gold
- (7) General anesthetics, upon demonstration of Medical Necessity
- (8) Antibiotic drugs
- (9) Patient consultations

Class C Services: Major Dental Procedures

- (1) Gold restorations, including inlays, onlays, and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold
- (2) Re-cementing bridges, crowns or inlays
- (3) Installation of crowns
- (4) Installing precision attachments for removable dentures
- (5) Installing partial, full or removable dentures to replace one or more natural teeth that were extracted while the person was covered for this benefit
- (6) Addition of clasp or rest to existing partial removable dentures
- (7) Initial installation of fixed bridgework to replace one or more natural teeth which were extracted while the person was covered for these benefits
- (8) Repair and/or adjustment of crowns, bridgework and removable dentures
- (9) Rebasing or relining of removable dentures
- (10) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. Will apply only if one of these tests is met:
 - (a) Replacement or addition of teeth is required because of one or more natural teeth being extracted after the person is covered under these benefits
 - (b) Existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable
 - (c) Existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed

Class D Services: Orthodontic Treatment and Appliances

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services are available to all members and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

Exclusions for your Dental Plan

Charges for the following are not covered:

- (1) Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan
- (2) Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting
- (3) The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge
- (4) Services that are excluded under Medical Plan Exclusions
- (5) Charges for services received as a result of Injury or Sickness caused or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit a crime, assault or other felonious behavior, or by participating in a riot or public disturbance
- (6) Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law
- (7) Oral hygiene, plaque control programs or dietary instructions
- (8) Implants including any appliances and/or crowns and the surgical insertion or removal of implants
- (9) Services that, to any extent, are payable under any medical benefits of the Plan
- (10) Care and treatment for which there would not have been a charge if no coverage had been in-force
- (11) Services which are not included in the list of covered dental services
- (12) Charges incurred for which the Plan has no legal obligation to pay
- (13) Care and treatment that is not Medically Necessary
- (14) Care and treatment of an Injury or Sickness that, in either case, is occupational -- that is, arises from work for wage or profit, including self-employment
- (15) Surgery to correct malpositions of the jaw bone
- (16) Personalization of dentures
- (17) Charges excluded or limited by the plan design as stated in this document
- (18) Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law
- (19) Replacement of lost or stolen appliances
- (20) Any loss due to an intentionally self-inflicted Injury, while sane or insane
- (21) Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic
- (22) All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome
- (23) Any loss that is due to a declared or undeclared act or war

Payment of your Claims

Payment of Claims:

Claims for participating providers must be submitted to the Health Plan address on the back of your ID card. If you receive a bill directly from your provider, contact their office and verify that they have billed your Health Plan and that they have the correct member information about you and your family.

Claims for non-contracted providers can also be submitted to the Health Plan. These claims will be processed following the out-of-network benefits. In cases of non-contracted providers, you may be asked to pay for the bill at the office. If this happens, please obtain an itemized bill, claim form, and your receipt, and submit these to the Health Plan for reimbursement of eligible charges.

Receiving an Explanation of Benefits (EOB):

When claims are paid, the Health Plan will send you an Explanation of Benefit (EOB). The EOB will provide explanation of how your claim was processed. It will identify the provider, date of service, patient seen, amount billed by provider, amount allowed per contract, amount that is patient responsibility, including deductible, copays, coinsurance and the amount that was paid to the provider. The EOB will also provide explanation for any charges not paid or denied.

Coordinating Benefits with other Plans:

Coordinating benefits is done when you have coverage for health benefits under more than one plan. This process determines which plan is required to pay first and to the extent that your other plan will pay benefits in order to avoid duplication of payment.

Remember that you must follow the rules of all plans that are being coordinated in order to receive benefits from this process. For our Health Plan remember to always use participating providers except for emergencies.

Your benefits may be reduced for any accident, disease, condition, or treatment, service, care, or procedure if they involve coordination with any automobile insurance plan; government sponsored health insurance program, such as Medicare or CHAMPUS; or worker's compensation.

ELIGIBILITY

Your Eligibility?

Employees are **eligible** for coverage based on position classification. **Coverage** will first of the month following 30 or 60 days, based upon position classification. See employee handbook for clarification or contact Human Resources for more information.

What is a Dependent?

- A covered employee's spouse, domestic partner, and unmarried children from birth to the limiting age of 26 years. The Dependent child must be primarily dependent upon the Employee for support and maintenance. When a child reaches the limiting age of 26, coverage will end the last day of the child's birthday month.
- The term "spouse shall mean the person recognized as the employee's husband or wife under the laws of the state where the employee lives.
- The term "domestic partner" shall mean a person who is over the age of 18 and mentally competent to this declaration; not married to, or legally separated from, anyone else; not related by blood to the covered employee to a degree of closeness that would prohibit legal marriage in the covered employee's state of legal residence; who has not had a different spouse or domestic partner within the last 6 months from the date of the execution of this declaration (this condition does not apply if you had a spouse or domestic partner who died); who resides with the covered employee and who intends to do so indefinitely; and who meets at least two of the following eligibility criteria: a) lived with the covered employee continuously for 12 months; b) executed a domestic partnership agreement in a jurisdiction which authorizes such agreements; c) named as a beneficiary under the covered employee's will; d) granted to the covered employee, or been granted by the covered employee, powers under a durable power of attorney; e) designated by the covered employee or designating the covered employee as a beneficiary under a life insurance policy; f) retain a joint bank account with the covered employee; g) cosigned a lease or deed with the covered employee; or h) named with the covered employee on the same care insurance policy.
- The term "children shall include natural children living in the same household as the employee, step-children, adopted children or children placed with an employee in anticipation of adoption.
- An unmarried child of whom the employee has been made the legal guardian.
- The term "child placed with an employee in anticipation of adoption" refers to a child whom the employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen as of the date of such placement for total or partial support of the child in anticipation of the adoption. The child must be available for adoption and the legal process must have already begun.
- A child of a plan participant who is an alternate recipient under a qualified medical child support order.
- A covered dependent child who reaches the limiting age of 26 and is *totally disabled*, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the employee for support and maintenance and unmarried.

Adding a Newborn or Adopted Dependent:

Coverage for a child born to you or your spouse will be effective from the date of birth, if you submit written request to the Health Plan **within 30 days** of the birth of the child. You are also required to pay any additional premiums that are due from adding this dependent. If you do not notify the Health Plan within 30 days, the dependent will not be covered and you will have to wait until the next open enrollment period to change benefits.

Coverage for a child adopted by you or your spouse will be effective from the date of adoption, if you submit written request to the Health Plan along with the adoption documentation **within 30 days** of the finalization of adoption. You are also required to pay any additional premiums that are due from adding this dependent. If you do not submit the request within 30 days for the qualifying even, you will have to wait until the next open enrollment period to change benefits.

Adding a New Spouse:

If you get married, you will have **30 days from the date of your marriage to submit a written request to add a dependent along with a copy of the marriage certificate**. Once written documentation is received, your dependent will be effective the first of the following month. If you do not submit the request within 30 days for the qualifying even, you will have to wait until the next open enrollment period to change benefits.

What Happens if you Waive Coverage?

If you waive coverage and are covered under a spouse's plan, and then lose coverage under that plan, you will have 30 days to enroll you and your dependents in our Health Plan. With a written request and proof of loss of coverage, your coverage for you and your dependents can be effective the first of the following month. If you do not submit the request **within 30 days** for the qualifying even, you will have to wait until the next open enrollment period to change benefits.

PRE-EXISTING CONDITION LIMITATIONS

What is a Pre-Existing Condition?

A pre-existing condition is a condition other, than pregnancy, for which medical advice, diagnosis, care or treatment, including the use of prescription drugs, was recommended or received from a licensed health provider during the 6-month period immediately preceding the earlier of the member's effective date of coverage under the Health Plan or the first day of any waiting period for coverage eligibility under the Health Plan. A genetic condition does not constitute a Preexisting Condition in the absence of a diagnosis of the condition related to the genetic information, and will not result in a Pre-existing Conditions Exclusion.

Benefits will **not** be paid for any services incurred by a member in connection with a Pre-existing Condition, unless the services are incurred after the member has been enrolled for coverage under the Medical Plan Benefit for 12 consecutive months, including any waiting period for coverage eligibility under the Health Plan.

No Pre-existing Conditions Exclusion will be applied to coverage for newborn children or adopted children under 18, including children placed for adoption, who are (or were) enrolled for coverage within the 30 day period of becoming eligible under this Health Plan or previous coverage for which they were eligible.

Obtaining Credit for prior Creditable Coverage:

The Pre-existing Conditions Exclusion period will be reduced by any prior Creditable Coverage that you had with a prior Health Plan, provided that there was no break in coverage exceeding 62 days. The 62-day period does not include any waiting period for coverage eligibility under the Health Plan. In order to receive this credit for prior coverage and possibly remove the pre-existing limitation, you must submit a certificate of coverage from your last insurance carrier to this Health Plan. The certificate of coverage will list the dates insured and the dependents covered. If the most recent certificate of coverage does not show coverage for at least 12 months, you will want to go back to the prior insurer and request a certificate of coverage from them also. If you can show twelve (12) months of continuous coverage, your pre-existing condition limitation can be removed. It is the employee's responsibility to request a certificate of coverage from their prior insurance plan and to submit it to us for review.

Creditable Coverage means any of the following

1. Another group plan (including continuation or conversion coverage)
2. Individual health coverage
3. Medicare Part A or B
4. Medicaid
5. CHAMPUS
6. Federal Employees Health Benefit Plan (FEHBP)
7. Medical care of the Indian Health service or of a tribal organization
8. A state health benefits risk pool
9. A public health plan
10. A Peace Corps health plan

APPEALS PROCESS

Concerns Regarding Payment or Denial of Claims:

If you have questions about a specific claim, contact the customer service department on the back of your ID Card.

If you have discussed your situation with the customer service department and are still dissatisfied with how your claim has been handled and they are unable to assist in getting the claim re-processed to your satisfaction you can file a formal appeal. You must file an appeal within 180 days of receiving communication from P5 on an adverse benefit determination. Formal appeal letters with a copy of the adverse benefit determination, if applicable, should be sent to: **P5 Health Plan Solutions, Attention: Appeals Coordinator, 2455 East Parleys Way, Suite 300, Salt Lake City, UT 84109-1217**. The Appeals committee will review your letter and you will receive a written response within 30 days from the date the Plan Administrator receives your request.

If you are still dissatisfied with the appeal results, please contact the HR Department at your Employer for assistance.

If you continue to have difficulty with the appeal's decision, then you can seek arbitration through the Utah Arbitration Act. This decision is compulsory and binding to all parties. The Utah Insurance Regulations require that we notify you of the following information regarding the process of arbitration: Any matter in dispute between the employer, subscriber, or member and the Health Plan is subject to compulsory arbitration following the exhaustion of the dispute resolution (Appeals) procedures provided by the Health Plan and outlined in the Master Group Contract. Such arbitration will be required instead of litigation and will be conducted according to the UTAH ARBITRATION ACT and the rules of the AMERICAN ARBITRATION ASSOCIATION. A copy of that act and those rules are available from the Health Plan upon request. Any arbitration decision shall be binding upon both the employer, subscriber, or member and the Health Plan. The arbitration award may include attorney fees, if allowed by state law and may be entered as a judgement in any court of proper jurisdiction. This arbitration requirement shall not apply to preclude any remedy required or available to members under the Federal ERISA Law. This provision also does not preclude any dispute resolution by any small claims court having jurisdiction.