# Schedule of Medical Benefits
# Town Of Biscoe Med 3000 30/40

**Features that Add Value**

- MIT Health Benefits Trust and your employer have chosen MedCost Benefit Services to administer their health plan benefits. With over a decade of experience in the health care industry, MedCost is a leader in benefits administration because of our outstanding service, respect for your personal health information, and our commitment to offering products and services that are important to you.
- At MedCost, we recognize that affordable health care is vital to your wellbeing and that of your family. We are dedicated to educating our members about the health care options available to them and helping them to become more informed health care consumers. We offer several interactive online tools so you can easily access the most up-to-date information regarding your health benefits.

**Quality Service Is Part of Quality Care**

- Service is at the heart of everything we do. Our goal is to give you: fast, accurate answers; responsive, courteous and professional assistance; and ease and convenience in finding the information you need to manage your health.
- **www.medcost.com** – For access to information 24/7, go to Member login to visit your personalized member website. You will need your ID card with your Member and Group ID numbers to create an account.
- If you have questions about claim status, benefits, or other general questions, you may contact MedCost Benefit Services Customer Service department at (800) 795-1023 or **mbscs@medcost.com**. Please include your Member ID number in the body of the email.

**Health and Wellness Toolkit**

Start now taking the first step toward building a healthier you! Studies show that by making healthy choices part of your lifestyle, you are more likely to continue with them. We offer you an online Health and Wellness Toolkit to show you how to make those changes. This toolkit is separated into four main sections, each very different but equally important:

- Fitness will guide you through implementing a walking exercise plan and stretching routine to improve your overall health and flexibility. You'll also find tips on how to increase your physical activity at work.
- Nutrition is based on the USDA Food Pyramid and will guide you through the food groups, serving sizes and healthy food and beverage choices. Find healthy recipes, too!
- Health covers conversations to have with your doctor and provides basic information on common health concerns and preventive screenings.
- Lifestyle discusses tobacco cessation, stress relief, sleep habits, and germs to help you change bad habits into healthy ones.

**It's Your Choice**

When you visit network providers, you get access to quality care at the lowest out-of-pocket costs available under your plan. Your plan also offers the freedom to choose the providers you prefer — even if they aren't part of the network. Your benefits are the highest when you see "participating providers," but you're still covered for visits to other providers.

**Prescription Drug Card**

Contact the Prescription Drug card administrator at the telephone number listed on your Identification Card with any questions regarding Prescription Drug card benefits.

**Wellness Requirements for 2021**

*Individual will pay 10% more premium if the following are not completed between July 1, 2019 and December 31, 2020.

- Wellness screening through our Wellness Initiative onsite or through member's Physician.
- Age appropriate cancer screenings per American Cancer Association guidelines.
- Participation in our Personal Care Management (PCM) program only if you are contacted by a MedCost PCM nurse.

*Wellness Requirements are not applicable to COBRA participants. Wellness Requirements are not applicable to pre-65 retirees as defined by the applicable governmental entity, unless specifically designated to apply by such governmental entity.

Your health plan is committed to helping you achieve your best health. All employees have the ability to avoid any applicable penalties relating to the wellness programs. If you think you might be unable to meet a standard to avoid a penalty under this wellness program, you might qualify for an opportunity to avoid the penalty by different means.

Contact Julie Hall at (919) 715-9782 or Lisa Ervin at (919) 715-7973 and we will work with you and, if you wish, with your doctor, to find a wellness program with the same reward that is right for you in light of your health status.

| SCHEDULE OF BENEFITS<br>Med 3000 30/40<br>2019 | |
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| For access to information 24/7, go to **www.medcost.com** and go to Member Login to visit the personalized website; use ID card with Member and Group ID numbers to create an account. For questions about claim status, benefits or other general questions, contact MedCost Benefit Services Customer Service at (800) 795-1023 or **mbscs@medcost.com**; please include Member ID in body of email.<br><br>This Schedule of Benefits is an outline of benefits of the Employee Benefit Plan provided by your Employer. The basis of payment of the benefits described herein will be determined by the provider of services and claims rules of the Plan. All benefits described in this Schedule are subject to the exclusions and limitations described more fully in the Summary Plan Description.<br><br>**See also Master Summary Plan Description for details of the Plan.** | |
| **Waiting Period** | Effective on date deemed by the governmental unit |
| **Spousal Definition** | The term "Spouse" means the person who is legally recognized as the husband or wife under the laws of the state where the marriage took place. The Employer may require documentation proving a legal marital relationship. |
| **Dependent Children** | Coverage for Dependent children is extended to the end of the month during which the 26th birthday occurs. |
| **Retirees / Board Members** | See Master Summary Plan Description / governmental unit for details. |
| **Open Enrollment** | Benefit choices made during Open Enrollment are effective on July 1st unless otherwise specified by governmental unit's Human Resources department. |
| **Leave of Absence** | FMLA. See Master Summary Plan Description.<br>Other than FMLA. See Master Summary Plan Description. |
| **Pre-Existing Conditions** | This Plan does not apply a pre-existing conditions exclusion period to any member. |
| **Network and Health Management** | |
| **Network / Travel Option** | As indicated on Identification card |
| **Precertification** | • Hospital admissions and Residential Treatment*<br>• Transplant services**<br>• Hospital observation unit stays of more than 48 hours<br>• Certain diagnostic services rendered as Outpatient or in Physician's office; see Outpatient Review below***<br>• Dialysis services****<br>• Intensive Outpatient and Partial Hospitalization***** |
| Penalties | *Non-precertified room and board charges will be denied.<br>**Failure to precertify Transplant Services will result in a 50% reduction in benefits.<br>***Non-precertified diagnostic services listed under Outpatient Review will be denied.<br>****Failure to precertify dialysis will result in associated charges from the first treatment date being denied.<br>*****Non-precertified days / visits will be denied. See Medical Benefit Exclusions and Defined Terms in Master Summary Plan Description. |
| **Outpatient Review** | Precertification is required for MRI, CT and PET scans performed in Physician's office or as an Outpatient. Service performed in emergent situations (to rule out need for surgery or urgent treatment) are not subject to the requirement for Outpatient Review / Precertification. |
| Penalty | Non-precertified diagnostic services listed under Outpatient Review will be denied. |
| **Case Management** | Life-altering injuries, illnesses and diagnoses need specialized care. MedCost has individualized intervention and care for those navigating severe health conditions. The goal of Case Management is to promote improved quality of life outcomes while ensuring the best use of available resources.<br><br>The Behavioral Health Solution program, a partnership with Carolina Behavioral Health Alliance (CBHA), is a component of Case Management that includes additional information, support and care for Plan Participants who are receiving Plan benefits for Mental Health and / or Substance Use Disorders.<br><br>See the remainder of the Summary Plan Description for additional details |

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| **Personal Care Management (PCM)** | | Personal Care Management (PCM) is individualized care designed to help create positive outcomes for those who are suffering from chronic conditions. | |
| **SmartStarts Prenatal Program** | | SmartStarts is a voluntary Employee wellness program, focused on educating expectant mothers and mentoring them through each trimester of Pregnancy. | |
| Incentive | | The Plan provides an incentive for participation in this program. If you are enrolled in SmartStarts during the first trimester, The MIT health plan will reimburse $150 (via a check), or if during the second trimester, $75 (via a check), upon completion of the program. For more information on the MedCost SmartStarts Program, call toll-free (800) 795-1023 and / or see Summary Plan Description (booklet). | |
| **Benefit Maximums / Deductibles / Out-of-Pocket** | | | |
| | | **In-Network** | **Non-Network** |
| This Plan does not apply a Lifetime or Annual Benefit Maximum to each Plan Participant for the total claim expenses incurred and paid while covered under this Plan. | | | |
| Deductible | Individual | $3,000 | $3,000 |
| | Family | $6,000 | $6,000 |
| Coinsurance Maximum | Individual | $1,500 | $2,000 |
| | Family | $3,000 | $4,000 |
| Out-of-Pocket Maximum | Individual | $4,500 | $5,000 |
| | Family | $9,000 | $10,000 |
| Out-of-Pocket Maximum includes Copays, Coinsurance, and Deductibles, and excludes non-covered services, premiums, and any applicable penalties.<br><br>Once the Out-of-Pocket Maximum is reached, the Plan pays 100% of eligible charges for the remainder of the Benefit Year, except for benefit penalties.<br>Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%. If the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%. | | | |
| | | Network and Non-Network Deductibles and Out-of-Pocket Maximums accumulate towards each other. | |
| Benefit Year | | January 1st through December 31st. | |
| **Inpatient Hospital Services** | | | |
| | | **In-Network** | **Non-Network** |
| **Room and Board**<br>Precertification required | | 80% after Deductible | 60% after Deductible |
| | | Includes the medical services and supplies furnished by a Hospital, Ambulatory Surgical Center or a Birthing Center; after 48 observation hours, a confinement will be considered an inpatient confinement and will require precertification.<br>If you occupy a private Hospital room, you will pay the difference between the Hospital's charges for a private room and the charge for a semiprivate room. If the Hospital does not have semiprivate rooms or a semiprivate room is unavailable, or your medical condition requires a private room (as determined by the Claims Administrator), the Plan will consider the private room rate.<br>Payment for Critical Care room and board will be based on the Hospital's ICU charge. | |
| **Physician Inpatient Services** | | 80% after Deductible | 60% after Deductible |
| | | The Plan covers professional services of a Physician for Inpatient surgical or medical services. When multiple procedures are performed during the same operative session, benefits will be based on Medically Necessary services. Allowable expenses will be determined based on the complexity of the procedures. 100% of the allowable expense for the most complex will be considered and 50% of the allowable expense or billed charge will be considered for each additional procedure. An assistant surgeon will be considered eligible when Medical Necessity has been determined based on standard practices. Benefits will be based on 20% of the allowable expense or billed charge. | |
| **Other Inpatient Services** | | 80% after Deductible | 60% after Deductible |
| **Emergency and Urgent Care Services** | | | |
| | | **In-Network** | **Non-Network** |
| **Emergency Room Treatment**, including related services | | $350 Copay<br>Note: Copay waived if admitted. | |

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| **Urgent Care Facility** | 80% after Deductible | 60% after Deductible |
| **Urgent Care** provided in a Physician's Office – **Primary Care** | $30 Copay per office visit | |
| **Urgent Care** provided in a Physician's Office – **Specialist** | $40 Copay per office visit | |
| **Outpatient Hospital Services** | | |
| | **In-Network** | **Non-Network** |
| **Pre-Admission Testing** | 80% after Deductible | 60% after Deductible |
| | The Plan will pay for diagnostic tests and X-rays when performed on an outpatient basis before a Hospital admission, provided the procedures are provided within 7 days of the admission, are related to the condition that causes the admission and are performed in lieu of tests while Hospital confined. Payment will be made even if tests show that the condition requires medical treatment prior to Hospital admission or the Hospital admission is not required. | |
| **Outpatient / Ambulatory Surgery** | | |
| Facility and Surgeon | 80% after Deductible | 60% after Deductible |
| | When multiple procedures are performed during the same operative session, benefits will be based on Medically Necessary services. Allowable expenses will be determined based on the complexity of the procedures. 100% of the allowable expense for the most complex will be considered and 50% of the allowable expense or billed charge will be considered for each additional procedure. An assistant surgeon will be considered eligible when Medical Necessity has been determined based on standard practices. Benefits will be based on 20% of the allowable expense or billed charge. | |
| **Outpatient Laboratory and X-Ray Services** | 100%; Deductible waived | 60% after Deductible |
| **Outpatient Diagnostic Scans** (MRI, CT, PET) Precertification required | 80% after Deductible | 60% after Deductible |
| **Other Outpatient Services** | 80% after Deductible | 60% after Deductible |
| **Physician Services** | | |
| | **In-Network** | **Non-Network** |
| **Office Visit for Injury / Illness** | | |
| **Primary Care** | $30 Copay per office visit | 60% after Deductible |
| | General practitioner, family practitioner, internist, pediatrician and OB-GYN. | |
| **Specialist** | $40 Copay per office visit | 60% after Deductible |
| | Copay covers most services including in-office surgery, laboratory and X-ray services, chemotherapy, radiation therapy, high intensity focused ultrasound (HIFU) for treatment of prostate cancer, infusion therapy (and injections other than Specialty Pharmacy) performed in and billed by the Network Physician's office. See also Specialty Pharmacy under Prescription Drugs. | |
| Services **not covered** by Copay: | Services not covered by an office visit Copay include, but are not limited to: MRI, CT scan, PET scan, dialysis services, prenatal and postnatal Physician visits. | |
| **PCP Office Injectables** | $30 Copay | 60% after Deductible |
| **Specialist Office Injectables** | $40 Copay | 60% after Deductible |
| **Office Injectables** | Certain Prescription Drugs must be purchased through the Plan's Specialty Pharmacy and will not be paid or reimbursed by the Plan if they are not procured through the Plan's Specialty Pharmacy. See Prescription Drug Benefits, Limitations and Exclusions for more information. | |
| **Second Surgical Opinions** | As any office visit | As any office visit |
| | Benefits will be provided to determine the Medical Necessity of an elective surgical procedure. The second opinion must be made by a board-certified Physician who is affiliated in the appropriate specialty, and who is not an associate of the attending Physician. | |
| **Routine Wellness / Preventive Services** | | |
| | **In-Network** | **Non-Network** |
| **Routine Wellness /** | 100%; Deductible waived | |

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| **Preventive Services** | *Non-Network limited to $500 maximum per Benefit Year |
| | Includes Physical or Gynecological exam, well child care, laboratory services, X-ray services, immunizations / vaccines / flu shots, health history, developmental assessment, colorectal screening, diabetes screening and education, pap smear, ovarian cancer screenings, PSAs, bone mass measurements, and family planning / contraceptive management. (Includes FDA approved contraceptive methods / devices and sterilization procedures and education and counseling for women, including devices, injectables and implants, excluding over-the counter products. Includes injectable contraceptives administered in the Physician's office. Oral contraceptives and patches are covered under the Prescription Drug Card.) Gynecologists may perform the Gynecological exam and pap smear, with the balance of the physical exam performed by another Physician. There will be no duplication of services. See also Colonoscopy and Mammogram. *Routine Wellness Non-Network limit coordinates with Colonoscopy, Mammogram and Nutritional Counseling.<br><br>The Patient Protection and Affordable Care Act (PPACA), as part of Health Care Reform, contains a provision that requires your health plan to provide certain preventive care services with no cost-sharing, i.e., not subject to Copays, coinsurance, or Deductibles. * These services include, but are not limited to: Routine physicals; Pediatric wellness examination; Selected preventive, diagnostic, and cancer screenings; and Certain Pediatric Preventive Services, including but not limited to, oral health assessment, sensory screening, and developmental and behavioral assessment.<br><br>These preventive services are covered based on the guidelines and recommendations of the United States Preventive Services Task Force (USPSTF). For a complete listing of these guidelines and recommendations please visit:<br>**https://www.healthcare.gov/coverage/preventive-care-benefits/**<br><br>Preventive Services for Women without cost share<br>(The following list is not all-inclusive.)<br>• Well-woman visits: Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including prenatal visits billed outside of global obstetric care.<br>• Screening for gestational diabetes.<br>• Testing for human papillomavirus (HPV test) annually or as recommended by Physician.<br>• Sterilization procedures and associated services rendered on the same day (Reversal procedures are not covered).<br>• Breastfeeding support and associated supplies and counseling. (Includes lactation support and counseling provided by a trained provider in conjunction with birth; also includes purchase, or rental cost up to purchase price, of breastfeeding equipment from a network provider if available. Purchase is limited to one per Pregnancy and purchase from a retail store is not covered.)<br>• Screening and counseling for interpersonal and domestic violence<br><br>These preventive services for women are covered based on recommendations of the independent Institute of Medicine and supported by the Health Resources and Services Administration.<br><br>The services shown under this section, "Routine Wellness / Preventive Services," are covered based on the guidelines and recommendations of the United States Preventive Services Task Force (USPSTF). For a complete listing of these guidelines and recommendations, please visit:<br>**https://www.healthcare.gov/coverage/preventive-care-benefits/**<br><br>*A plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for which a recommended preventive service will be available without cost-sharing to the extent not specified in a recommendation or guideline. |
| **Nutritional Counseling**<br>See also Diabetes Care | 100%; Deductible waived<br>*Non-Network limited / combined with Routine Wellness $500 maximum per Benefit |

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| Management and non-surgical treatment of obesity / Morbid Obesity | Year | |
| | Medical Nutritional Counseling is covered when rendered by a licensed health care provider, in-network when available, as required to provide appropriate guidance and education for diet related conditions or risk factors, including but not limited to diabetes, obesity, high cholesterol and high blood pressure. Includes up to 6 visits in a Benefit Year. | |
| **Other Services** | | |
| | **In-Network** | **Non-Network** |
| **Advanced Imaging** Precertification required | 80% after Deductible | 60% after Deductible |
| | MRI, CT, PET scans performed as an Outpatient or in a Physician's Office. | |
| **Allergy Services** Testing, Treatment and Injections | 100%; Deductible waived | 60% after Deductible |
| | The Plan will pay for Medically Necessary tests to determine the nature of allergies and for desensitization treatment (allergy "shots") to treat allergies. Allergy nurse visits, antigen / serum, testing, and treatment materials are also included. | |
| **Ambulance, Air**<br><br>Precertification required when non-emergent | 80% after In-Network Deductible | |
| | Benefits are for Medically Necessary professional air ambulance services. A charge for this item will be a Covered Charge when services are provided by, and in, an air ambulance traveling from the original pickup site to a Hospital or treatment facility when such a facility is the closest one that can provide covered services appropriate to the Plan Participant's condition, unless the Plan Administrator finds a longer trip is Medically Necessary. Non-emergency air ambulance services are eligible for coverage only when ground transportation is not medically appropriate due to the severity of the Injury or Illness, or the pick-up point is inaccessible by land, and such services are precertified. Non-emergency air ambulance services require verification of Medical Necessity or services will not be covered. | |
| **Ambulance, Ground** | 80% after In-Network Deductible | |
| | Benefits are for local Medically Necessary professional ground ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip is Medically Necessary.<br><br>The Plan covers services in a ground ambulance traveling:<br>• from a Plan Participant's home, scene of an Accident, or site of an emergency to a Hospital;<br>• between Hospitals; and<br>• between a Hospital and a Skilled Nursing Facility when such a facility is the closest one that can provide covered services appropriate to the Plan Participant's condition. Benefits may also be provided for ambulance services from a Hospital or Skilled Nursing Facility to a Plan Participant's home when this is Medically Necessary. | |
| **Applied Behavioral Analysis (ABA) Therapy** for Autism Spectrum Disorders (ASD) | $40 Copay per visit | 60% after Deductible |
| | Limited to a Benefit Year maximum of 150 visits or $40,000, whichever is reached first.<br><br>ABA therapy is covered for the treatment of Autism Spectrum Disorders (ASD) provided services are rendered by an appropriately credentialed Physician who is licensed for the provision of such services. Short-Term Therapy other than ABA therapy may be required for treatment of ASD. See also Short-Term Therapy for coverage of physical therapy, occupational therapy, and speech therapy. See also exclusion for learning disorders / developmental testing. | |

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<tr><td>CAM Program<br>(Complementary or Alternative Medicine)</td><td>$30 Copay per visit<br>Benefits limited to Benefit Year maximum of $1,000 per covered Employee, covered Spouse and covered Dependent.<br><br>MIT offers the CAM Program (Complementary or Alternative Medicine) for all covered members to encourage the pursuit of wellness.<br><br>When the Plan Participant is the recipient of one of the treatments listed below, the fee should be paid to the provider at the time the service is rendered. Please refer to Master Medical SPD, Claims Procedures and Appeals for claim steps in order to file for reimbursement. For a special claim form, visit www.medcost.com or contact MedCost Benefit Services Customer Service department at (800) 795-1023 or mbscs@medcost.com.<br><br>*The CAM Program provides coverage of the following complementary and alternative treatments of medical conditions.<br>Acupuncture – Acupuncture is a practice in which fine needles are inserted into the skin to stimulate specific points in the body.<br>Acupressure – Acupressure involves massaging certain points on the body to relax muscles, balance your natural energy flow, and relieve stress and pain.<br>Ayurvedic medicine – Ayurveda is based on the belief that health and wellness depend on a delicate balance between the mind, body, and spirit. Its main goal is to promote good health, not fight disease.<br>Biofeedback – Biofeedback is a method used to help a person learn stress-reduction skills by providing information about muscle tension, heart rate, and other vital signs as the person attempts to relax.<br>Energy medicine (see Qi Gong and Reiki)<br>Functional medicine. Please see Appendix B in Master Medical SPD for more information.<br>Homeopathy – Homeopathy is a medical system based on the belief that the body can cure itself. Those who practice it use tiny amounts of natural substances, like plants and minerals.<br>Hypnotherapy – Hypnotherapy uses guided relaxation, intense concentration, and focused attention to achieve a heightened state of awareness. Hypnotherapy can help some people change certain behaviors, such as to stop smoking or nail-biting. It can also help in treating certain kinds of pain.<br>Integrative medicine. Please see Appendix B in Master Medical SPD for more information.<br>Massage therapy – Massage therapy is a form of hand-applied pressure-point treatment that can reduce pain, anxiety, fatigue, and nausea.<br>Naturopathy – Naturopathic medicine is a system that uses natural remedies (including herbs, massage, acupuncture, exercise, and nutritional counseling) to help the body heal itself. The Plan covers herbs purchased from the provider only / excludes retail purchase of herbs.<br>Qi Gong – Qi Gong is a Chinese form of moving meditation.<br>Reiki – Reiki is a form of “touch” therapy that realigns your body’s energy balance. It can make it easier to manage pain, stress, and worry.<br>Traditional Chinese / Asian medicine<br>Yoga therapy – Yoga is a form of exercise with specific poses or sets of movements that can be combined with deep breathing to help ease stress, anxiety, and fatigue, and help you sleep better.<br><br>The above listed definitions are from https://www.webmd.com/ visited April 3, 2018.<br><br>NOTICE<br>By submitting a claim for reimbursement under this benefit, you are representing that the provider to be paid for the services rendered maintains all necessary and appropriate licensure and / or certification for the applicable services in the state where the services were rendered.<br><br>See also the Master Medical SPD, Appendix B, for more information on the subjects of complementary medicine, alternative medicine, integrative medicine, and functional medicine.</td></tr>
<tr><td>Chemotherapy / Radiation / High Intensity Focused Ultrasound / Infusion</td><td>80% after Deductible | 60% after Deductible<br>Outpatient facility. See also Office Visit for Injury / Illness. Benefit includes treatment with radioactive substances as well as materials and services of technicians, and high intensity focused ultrasound (HIFU) for treatment of prostate cancer.</td></tr>
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| **Therapy** | | |
| **Chiropractic Services** | $40 Copay per office visit | 60% after Deductible |
| | Benefits limited to Benefit Year maximum of 25 visits.<br>Benefits covered when performed by a licensed M.D., D.O. or D.C.; the following services are not within the scope of a chiropractor's scope of practice and are excluded by the Plan: administering or prescribing medicine or drugs; the practice of osteopathy; diagnostic services and surgery. | |
| **Colonoscopy** | | |
| **First Colonoscopy per Benefit Year** | 100%; Deductible waived<br>*Non-Network limited/combined with Routine Wellness $500 maximum per Benefit Year | |
| | Includes the first colonoscopy per Benefit Year, other than inpatient, whether routine or non-routine. Includes polyp removal during routine colonoscopy when billed properly by the provider.<br>*Routine Wellness Non-Network limit coordinates with Nutritional Counseling and Routine mammograms and colonoscopies. | |
| **Colonoscopy –** Routine Subsequent in Same Benefit Year | 100%; Deductible waived<br>*Non-Network limited/combined with Routine Wellness $500 maximum per Benefit Year | |
| | If first in Benefit Year was non-routine:<br>Includes routine colonoscopy and related services, other than inpatient. Includes polyp removal during routine colonoscopy when billed properly by the provider.<br>*Routine Wellness Non-Network limit coordinates with Nutritional Counseling and Routine mammograms and colonoscopies. | |
| **Colonoscopy –** Non-Routine Subsequent in Same Benefit Year | 80% after Deductible | 60% after Deductible** |
| | If first in Benefit Year was routine:<br>Includes colonoscopy and related services, other than routine, and other than inpatient.<br>**Non-Network limited to $500 maximum per Benefit Year (separate from Routine Wellness / Routine mammogram / Routine colonoscopy limit) | |
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| **Dialysis Management Program**<br><br>Other than Inpatient – Precertification required | 80% after In-Network Deductible | |
| | Failure to precertify dialysis will result in associated charges from the first treatment date being denied.<br><br>Charges for professional fees and services, supplies, medications, labs and facility fees related to Outpatient dialysis are covered expenses. These services include but are not limited to hemodialysis, home hemodialysis, peritoneal dialysis and hemofiltration.<br><br>Effective July 1, 2017, the Plan will allow billed charges at the defined benefit in the Schedule of Benefits for 42 Outpatient dialysis treatments. This Plan does not provide Network level benefits for dialysis providers; therefore, benefits are not subject to discount arrangements that the provider may have in place with any Network.<br><br>For subsequent treatments the Plan allowable for dialysis will be limited to 140% of current year Medicare composite allowable. The Plan will pay according to the schedule for the next 30 consecutive months of dialysis or until the Plan is secondary to other coverage, whichever occurs first. Thereafter, as permitted in 42 CFR § 411.161(c) and (d), Medicare will be the primary payer and the Plan will only pay secondary to Medicare or other coverage. The Plan will reimburse Medicare Part B premiums for the individual if and for as long as enrolled in Medicare Part B and receiving benefits under this provision. Note: Medicare Part B premiums shall be reimbursed quarterly. | |
| **Durable Medical Equipment** | 80% after Deductible | 60% after Deductible |
| | The Plan has benefits for the rental of Durable Medical Equipment (DME) if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase. DME includes, but is not limited to, crutches, apnea monitors, glucometers, oxygen equipment, Hospital type beds and wheelchairs. See Defined Terms. | |
| **Hearing Aids** | 80% after Deductible | 60% after Deductible |
| | Benefit limited to Benefit Year maximum of $1,000.<br>Hearing aids ordered by a Physician or audiologist are covered for one hearing aid per ear every 36 months, including related services for initial hearing aids, replacement hearing aids, new hearing aids when alterations cannot adequately meet the needs of the individual, initial hearing aid evaluation, fitting, adjustments and supplies including | |

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| | ear molds. | |
| **Home Health Care** (including Private Duty Nursing, excluding Outpatient) | 80% after Deductible | 60% after Deductible |
| | Benefits limited to Daily maximum of 16 hours.<br>Services and supplies are covered only for care and treatment of an Injury or Illness.<br>The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.<br>A home health care visit means a visit by a member of a home health care team. Each visit that lasts for a period of 4 hours or less is treated as one home health care visit. If the visit exceeds 4 hours, each period of 4 hours is treated as one visit, and any part of a 4-hour period that remains is treated as one home visit.<br>Private duty nursing is covered when performed by a licensed nurse (R.N., L.P.N. or L.V.N.) and only when care is Medically Necessary, is not Custodial in nature and the Hospital's Intensive Care Unit is filled, or the Hospital has no Intensive Care Unit.<br>The only charges covered for Outpatient nursing care are those shown under Home Health Care. Outpatient private duty nursing care on a 24-hour-shift basis is not covered. | |
| **Hospice Care** | 80% after Deductible | 60% after Deductible |
| | Hospice care can provide the physical, psychological, spiritual and social support needed to help terminally ill patients and their families cope with the Illness. Care includes services provided by a Hospice program in the patient's home, a Hospital or a Hospice. These services are covered as long as they are prescribed by a Physician and the covered patient's life expectancy is six months or less.<br>Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Employee, covered Spouse and/or covered Dependent Children) are covered. Bereavement services must be furnished within six months following the patient's death. | |
| **Infertility Diagnostic Services** | As any medical expense | As any medical expense |
| | The Plan will cover diagnostic services to determine the cause of infertility. Treatment of infertility is not covered by the Plan. Infertility Services are available to covered Employee and covered Spouse only. See also Infertility exclusion and Surrogacy exclusion under Medical Benefit Exclusions. | |
| **Laboratory and X-Ray Services** | 100%; Deductible waived | 60% after Deductible |
| | Hospital Outpatient or Independent Outpatient Facility. | |
| **Mammogram** | | |
| **First Mammogram per Benefit Year** | 100%; Deductible waived<br>*Non-Network limited/combined with Routine Wellness $500 maximum per Benefit Year | |
| | Includes the first mammogram and related services per Benefit Year, other than inpatient, whether routine or non-routine.<br>*Routine Wellness Non-Network limit coordinates with Nutritional Counseling and Routine mammograms and colonoscopies. | |
| **Mammogram –** Routine Subsequent in Same Benefit Year | 100%; Deductible waived<br>*Non-Network limited/combined with Routine Wellness $500 maximum per Benefit Year | |
| | If first in Benefit Year was non-routine:<br>Includes routine mammogram and related services, other than inpatient.<br>*Routine Wellness Non-Network limit coordinates with Nutritional Counseling and Routine mammograms and colonoscopies. | |
| **Mammogram –** Non-Routine Subsequent in Same Benefit Year | 80% after Deductible | 60% after Deductible** |
| | If first in Benefit Year was routine:<br>Includes mammogram and related services, other than routine, and other than inpatient.<br>**Non-Network limited to $500 maximum per Benefit Year (separate from Routine Wellness / Routine mammogram / Routine colonoscopy limit) | |
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| **Medical Supplies** | 80% after Deductible | 60% after Deductible |
| **Maternity Care Services** | | |
| Initial Visit to Confirm Pregnancy | As any Physician office visit | As any Physician office visit |
| Physician (Global Fee) | $150 Copay then 100%; Deductible waived | 60% after Deductible |
| Facility | 80% after Deductible | 60% after Deductible |
| | Charges for the care and treatment of Pregnancy are covered the same as any other | |

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| | Illness for a covered Employee, covered Spouse and a covered Dependent child.<br><br>Maternity Care Services for all covered adult women, including Dependent daughters, include Prenatal Care with no cost-share as required by PPACA, if billed independently. See Routine Wellness/Preventive Services. See Defined Terms. | |
| **Newborn Nursery** | Routine newborn nursery and Physician care while the newborn is Hospital-confined typically includes room and board along with ancillary charges for the normal care of a newborn. Charges in these circumstances will be applied to the Plan of the mother, with Physician charges subject to Deductible.<br><br>Non-routine newborn nursery and Physician care will not be eligible for reimbursement under the Plan until the newborn is enrolled as a Dependent under the Plan enrollment provisions.<br><br>For details about enrolling newborn children, please see "Enrollment Requirements for Newborn Children," the Special Enrollment provisions, and "Open Enrollment," all in the Enrollment section. | |
| **Mental Health and Substance Use Disorders** | | |
| Inpatient | As any admission | As any admission |
| Outpatient Facility | As any outpatient facility service | As any outpatient facility service |
| Outpatient Physician | 100%; Deductible waived per office visit | 60% after Deductible |
| | Psychiatrists (M.D.), psychologists (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners may be asked to file claims under the direction of these professionals, depending on credentialing guidelines.<br>This Plan has partnered with an online service known as "myStrength" which offers web and mobile self-help resources, empowering Plan Participants to better manage depression, anxiety, and Substance Use Disorders while improving overall well-being. To obtain more information or to register, visit: **http://bh.mystrength.com/medcost** | |
| **Obesity, Non-Surgical Medical Treatment** | As any Covered Medical Expense | As any Covered Medical Expense |
| | Medically Necessary treatment of obesity and/or Morbid Obesity is covered. This does not include any form of food supplement, exercise program, exercise equipment, weight control program, injection of any fluid, use of medications or educational program, if not otherwise covered. | |
| **Obesity, Surgical Treatment**<br>Precertification required | As any Covered Medical Expense | As any Covered Medical Expense |
| | Medically Necessary charges for the surgical treatment of obesity will be covered, subject to these requirements and limitations:<br>• The Plan Participant must have a history of obesity and/or a Morbid Obesity Diagnosis for at least five years;<br>• During the past two years that a Plan Participant has been covered by this Plan, he/she must have a documented history of participating in a 12-month medically supervised weight loss program;<br>• The Plan Participant must have documented proof of adequate preoperative evaluations for surgery, which includes patient's understanding of the procedure, the procedure's risks and benefits, the length of stay in the Hospital, behavioral changes required prior to and after the surgery (including dietary and exercise requirements), follow-up requirements and anticipated psychological changes;<br>• Psychological assessment by a mental health professional of the patient's ability to understand and adhere to the program. The assessment must include expected levels of depression, eating behaviors, stress management, cognitive abilities, social functioning, self-esteem, personality factors or other mental health diagnoses that may affect treatment, readiness and ability to adhere to required lifestyle modifications and follow-up/social support.<br>• The Plan Participant must be an acceptable age (at least 18 years old at the time of the surgery) and risk for surgery as determined by his/her primary care or family Physician and the attending surgeon;<br>Precertification of the surgery is required. | |
| **Orthotics** | 80% after Deductible | 60% after Deductible |
| | Orthotics are covered for the initial purchase and fitting of an appliance designed for the support of weak or ineffective joints or muscles as a result of a disabling congenital condition or an Injury or Illness. Orthopedic foot appliances, including custom molded foot orthotics, may be covered when used as an integral part of a brace, applied tightly | |

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| | thereto, or when used to treat a condition requiring more than a supportive device of the foot. Shoe inserts are not considered orthotic devices by this Plan and are not covered. | |
| **Prosthetics** | 80% after Deductible | 60% after Deductible |
| | Benefit covers the initial purchase and fitting of a fitted artificial device to replace or augment a missing or impaired part of the body. Prosthetic devices include, but are not limited to, artificial limbs, breast prosthesis, cochlear implants and implanted lenses after cataract surgery.<br>Repair and replacement of a device will not be made more than once every 5 years, unless it is determined Medically Necessary due to a pathological change, such as growth, shrinkage, or atrophy that results in improper fit. Replacements will not be made because the device is lost, misplaced, or stolen. | |
| **Service Animal** | 80% after Network Deductible | |
| | For covered Dependents to age 19 only:<br>The Plan provides coverage for the purchase of a Medically Necessary service animal to a Lifetime maximum of $20,000. This benefit is subject to written approval for determination of Medical Necessity by the Plan Administrator and approval of the service animal distributor. | |
| **Short-Term Therapy** | $40 Copay per office visit | 60% after Deductible |
| | The Plan provides coverage for short-term rehabilitative therapy that is part of a rehabilitation program, including the therapies listed when provided in the most medically appropriate setting.<br>See also Applied Behavioral Analysis (ABA) Therapy under Other Services in this Schedule of Benefits. | |
| Cardiac | Covered as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan. | |
| Cognitive | Covered as deemed Medically Necessary provided services are rendered under the supervision of a Physician. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions that are subject to significant improvement through short-term therapy. | |
| Occupational | Covered when performed by a licensed occupational therapist or a Physician working within the scope of his/her license. Therapy must be ordered by a Physician, result from an Injury or Illness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy. | |
| Physical | Covered when performed by a licensed physical therapist or a Physician working within the scope of his/her license. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions that are subject to significant improvement through short-term therapy. | |
| Pulmonary | Covered when performed by a licensed respiratory therapist or a Physician working within the scope of his/her license. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions that are subject to significant improvement through short-term therapy. | |
| Speech | Covered when performed by a licensed speech therapist or a Physician working within the scope of his/her license; therapy must be ordered by a Physician: a) for speech disorders; b) following surgery for correction of a congenital condition of the oral cavity, throat or nasal complex; or c) to restore speech to a person who has lost existing speech function as a result of injury or an illness that is other than a learning or mental disorder. | |
| **Skilled Nursing Facility** | 80% after Network Deductible | |
| | Benefits limited to Benefit Year maximum of 100 days.<br>Benefits are payable if and when the patient is confined as a bed patient in the facility; the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and the attending Physician completes a treatment plan that includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility. Covered charges for a Plan Participant's care in these facilities are limited to the facility's semiprivate room rate. | |
| **Teladoc** | 100%; Deductible waived | |

<table>
<tr><td>Telemedicine other than Teladoc</td><td colspan="2">As any other covered office service</td><td>As any other covered office service</td></tr>
<tr><td rowspan="2">TMJ</td><td colspan="2">As any other Covered Medical Expense</td><td>As any other Covered Medical Expense</td></tr>
<tr><td colspan="3">Includes Surgical and Non-Surgical; excludes appliances and orthodontic treatment.</td></tr>
<tr><td rowspan="3">Transplant Services<br>Precertification required</td><td>Approved / Designated Facility</td><td colspan="2">Non-Approved / Non-Designated Facility</td></tr>
<tr><td>100%; Deductible waived</td><td colspan="2">60% after Deductible</td></tr>
<tr><td colspan="3">MedCost Health Management must be notified PRIOR to a Transplant evaluation.<br>All Transplant Services MUST be precertified and require participation in Case Management to qualify for Precertification. Failure to precertify or participate in Case Management will result in a 50% reduction in benefits. Refer to Health Management Services for details.<br><br>Human organ and tissue transplants are covered except those classified as "Experimental and/or Investigational."<br><br>*Travel and lodging will be paid by the Plan for the patient and one companion or caregiver (for both parents or for both guardians if the patient is a minor), up to a Lifetime maximum of $10,000. Travel must be to a Designated Transplant Provider that is more than 60 miles from the patient’s home.<br><br>Donor Charges<br>Both the recipient and the donor are entitled to benefits of Transplant Service coverage under this Plan when the recipient is a Plan Participant. Benefits provided to the donor will be charged against the recipient’s coverage.<br><br>The Plan will pay for typing, surgical procedure, mobilization, storage expenses, and costs directly related to the donation of a human organ or human tissue used in a covered Transplant procedure.<br><br>If a Plan Participant wishes to be a donor, the Plan will cover donor charges only if the recipient is also a Plan Participant. Donor expenses for recipients who are not Plan Participants are not covered under this Plan.<br><br>Claims Steps:<br>• When a Plan Participant is the recipient of an organ from a non-Plan donor, eligible expenses should be filed using the Plan Participant’s name and his or her alternate identification number.<br>• To help identify non-Plan donor claims billed under the Plan Participant recipient’s information, the donor claim should include the following:<br>o Diagnosis that indicates donor;<br>o Attachment that indicates the patient is a donor; and<br>o Donor’s information in the comments field of the UB-04 or other electronic claim.<br><br>*Exclusions:<br>Charges for the following are not covered:<br>• Mileage for sightseeing or visits to friends / relatives.<br>• Alcohol.<br>• Clothing.<br>• Entertainment (i.e., movies or rentals, visits to museums, mileage for sightseeing, compact discs, games, etc.).<br>• Expense for persons other than the patient and his / her covered companion or caregiver.<br>• Expenses for lodging when member or companion is staying with a relative or friend.<br>• Travel and non-medical room and board for a live donor or for family members of the donor.<br>• Gift cards.<br>• Groceries (i.e., grocery stores, Wal-Mart, K-Mart, etc.).<br>• Laundry service / supplies.<br>• Non-legible receipts (i.e., food or lodging).<br>• Paper products (i.e., paper plates, paper towels, napkins, etc.).</td></tr>
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| | • Parking fees incurred other than at hotel / motel or hospital.<br>• Personal care services (i.e., massage, spa, hair care services, etc.)<br>• Personal hygiene items (i.e., toothbrush, deodorant, etc.).<br>• Personal services (i.e., child care, house sitting, kennel care, etc.).<br>• Shoes / slippers.<br>• Souvenirs (i.e., T-shirts, sweatshirts, toys, etc.).<br>• Telephone bills / calls / phone cards.<br>• Tobacco or medical marijuana.<br>• Valet parking. | |
| | **In-Network** | **Non-Network** |
| **Wig Therapy** | 80% after Deductible | 60% after Deductible |
| | Following cancer treatment. Benefits limited to Lifetime maximum of one wig. | |
| **All Other Covered Services** | 80% after Deductible | 60% after Deductible |
| **Additional Services Covered Under the Medical Benefits** | | |
| **Anesthetics** and certain other items including administration | Certain items including anesthetics; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions are covered, including the administration thereof. | |
| **Attention Deficit / Hyperactivity Disorder** | Attention Deficit / Hyperactivity Disorder is covered as any other expense. | |
| **Dental Services** | Certain dental procedures will be Covered Charges under Medical Benefits:<br>• Removal of wisdom teeth.<br>• Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.<br>• Emergency repair due to Injury to sound natural teeth.<br>• Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.<br>• Excision of benign bony growths of the jaw and hard palate.<br>• External incision and drainage of cellulitis.<br>• Incision of sensory sinuses, salivary glands or ducts.<br>• Reduction of dislocations and excision of temporomandibular joints (TMJs).<br>• When Medically Necessary, replacement of teeth lost as a direct result of chemotherapy and/or radiation treatment.<br>• Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:<br>  • the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or<br>  • the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or<br>  • the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.<br>Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.<br><br>No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures. Oral surgeons will be paid at the Network level of benefits. | |
| **Anesthesia and Facility for certain Dental Procedures** | Charges are covered (under Medical Benefits) that are made by a Hospital or Ambulatory Surgical Facility for anesthesia and facility charges for services performed in the facility in connection with dental procedures for:<br>(a) Dependent children below age 9;<br>(b) Covered persons with serious mental or physical conditions; or<br>(c) Covered persons with significant behavioral problems.<br>The treating provider must certify that either hospitalization or general anesthesia is required in order to safely and effectively perform the procedure because of the person's age, condition or problem. | |
| **Diabetes Care** | The Plan will provide coverage for Medically Necessary diabetes self-management | |

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| **Management** other than Nutritional Counseling | training and educational services. | |
| **Eyeglasses, Lenses, Frames** | Medical benefits cover purchase of the first pair of eyeglasses, lenses, frames or contact lenses as prescribed following keratoconus or cataract surgery. | |
| **Family Therapy / Counseling** | Family Therapy/Counseling is considered an eligible expense when provided by a licensed mental health practitioner. | |
| **Genetic Testing** | Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease.<br><br>Genetic testing is considered Medically Necessary (and therefore covered) based on the diagnosis, provided:<br>• a person has symptoms or signs of a genetically-linked inheritable disease or<br>• the testing is performed as part of oncology treatment.<br><br>Genetic testing requires documentation of Medical Necessity via medical records or a letter of Medical Necessity if:<br>• it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome or<br>• the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer reviewed, evidence-based, scientific literature to directly impact treatment options as outlined in the letter of Medical Necessity noted above; or<br>• in accordance with the guidelines and recommendations established under PPACA for preventive services for women with no cost-share.<br><br>If genetic testing is determined to be Medically Necessary and meets the criteria outlined above, genetic counseling may be covered. Genetic counseling is limited to 3 visits per Benefit Year. | |
| **Reconstructive Surgery** | Covered Charges are:<br>• surgical correction of a congenital anomaly in a covered Dependent child;<br>• treatment of an Accidental bodily Injury; and<br>• reconstructive breast surgery following mastectomy. This mammoplasty coverage, in compliance with the Women's Health and Cancer Rights Act of 1998, will include reimbursement for (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (3) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient. | |
| **Routine Costs Associated with a Clinical Trial** | Includes charges for Routine Patient Costs incurred by a Qualified Individual in an Approved Clinical Trial subject to the terms of this Plan. The Plan may require a copy of the Approved Clinical Trial's patient consent packet before determining if any benefits are payable by the Plan (see Routine Patient Costs). Coverage is provided only for Routine Patient Costs of services associated with the Approved Clinical Trial, and only to the extent such Routine Patient Costs have not been, or are not, funded by other resources. See also Medical Benefit Exclusions and Defined Terms for more information regarding coverage of Routine Patient Costs associated with an Approved Clinical Trial. | |
| **Sleep Studies** | Sleep studies are covered as any Outpatient lab or independent lab when determined to be Medically Necessary. | |
| **Sterilization Procedures** | Sterilization procedures are covered as any expense unless otherwise noted in the SPD. Reversal procedures are not covered. | |
| **Termination of Pregnancy** | Abortions are covered for all Employees and Spouses who are Plan Participants when the life of the mother would be endangered if the unborn child was carried to term or the Pregnancy is the result of rape or incest. Complications of abortion are covered for all Employees and Spouses who are Plan Participants. Abortions and / or complications of abortion are not covered for Dependent Daughters. | |
| **Prescription Drug Benefits** | | |
| Prescription Drug Copays accumulate toward the Plan's overall Network Out-of-Pocket Maximum. | | |
| | **Retail Pharmacy** | **Mail Order** |

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| | Copay covers up to a 30 day supply. | Copay covers up to a 90 day supply. |
| Generic | $5 Copay | $10 Copay |
| Preferred Brand | $30 Copay | $75 Copay |
| Non-Preferred Brand | $50 Copay | $140 Copay |
| Mandatory Specialty Pharmacy | $75 Copay | |
| | Certain Prescription Drugs must be purchased through the Plan's Specialty Pharmacy and will not be paid or reimbursed by the Plan if they are not procured through the Plan's Specialty Pharmacy. See Prescription Drug Benefits, Limitations and Exclusions for more information. | |
| Miscellaneous Notes | Contraceptives: Includes preventive services for women as required by Healthcare Reform without cost share for prescribed FDA approved contraceptives, whether generic or brand if generic is unavailable, including: oral contraceptives, transdermal and vaginal ring. (Contraceptive devices, injectables and implants, while excluded under Prescription Drug benefits are included under the medical benefits. See Contraceptive Management under Routine Wellness section.)<br><br>If a Generic Drug version is not available or would not be medically appropriate (as determined by your health care provider) a prescribed FDA-approved Brand Name contraceptive method will be paid by the Plan with no cost-sharing.<br><br>Smoking Cessation Products: Included with prescription without cost share: Nicotine replacement therapy (i.e., gum, lozenge, transdermal patches, inhaler and nasal spray), Sustained release Bupropion, Varenicline.<br><br>Preventive Medications: Includes certain prescribed over-the-counter products without cost share as required by PPACA.<br><br>Contact the drug card administrator at the telephone number listed on your ID card with questions or more information about drug availability or coverage of specialty drugs. | |
| **Please refer to Summary Plan Description (SPD) for further details on benefit provisions, definitions and exclusions. In the event of discrepancy between this Schedule and the Summary Plan Description (booklet), the approved Summary Plan Description (booklet) will govern.** | | |