BasicCare Program

Summary Plan Description of the

University of IL BasicCare Program

(the "Benefit Program")

This booklet provides important information about the Benefit Program offered by your Employer.

PLEASE NOTE: A person can only be covered if eligible for the coverage; if enrolled; and if the required premium has been paid. If you have any questions about your enrollment status, please contact your Employer.

The BasicAdvantage Total Coverage described in this Summary Plan Description is not a substitute for comprehensive health insurance and does not qualify as minimum essential health coverage under the Affordable Care Act.

The Essential Coverage described in this Summary Plan Description is intended to provide minimum essential coverage under the Affordable Care Act.

This booklet, together with the copy of the form used to enroll, makes up the Summary Plan Description.

TABLE OF CONTENTS

BENEFIT PROGRAM INFORMATION

Carrier:	Reliance Standard Life Insurance Company
Carrier's Address:	1700 Market Street, Suite 1200, Philadelphia, PA 19103-3938

IMPORTANT FACTS ABOUT THE BENEFIT PROGRAM

Eligibility:	The first day of the month following the date of hire
Coverage Begins:	The first day of the month following your enrollment provided you are eligible and the required premium has been paid.
Coverage Year:	January 1 – December 31

INFORMATION

Policy Holder Name:	University of IL BasicCare Program
Plan Administrator:	Julie Nelson University Payroll & Benefits Henry Administration Building, Room 177 (MC318) 506 S. Wright Street Urbana, IL 61801 Phone: (217) 265-6363 Fax: (217) 244-3135
Agent for Service:	Julie Nelson University Payroll & Benefits Henry Administration Building, Room 177 (MC318) 506 S. Wright Street Urbana, IL 61801 Phone: (217) 265-6363 Fax: (217) 244-3135
Employer Identification #:	37-6000511

The terms and conditions of the benefits described in this booklet apply to most states; however, state laws do vary. The laws of the state in which the carrier issues the group policies may affect this Benefit Program. These differences generally do not reduce your benefits. For more information regarding any changes in your coverage because of these variances, please see the next page.

Questions?
Call RSL Specialty Products Administration at 1-866-375-0775; representatives are ready to answer your coverage questions Monday through Friday, from 8:30 am to 5:30 pm, ET.

You also may get more information, download claim forms, check claim status or request a new ID Card by visiting our website at www.helpwithmyplan.com.

Preguntas? Este folleto contiene un resumen en ingles de su Programa de Beneficios de Grupo. Si usted tiene dificultad en entender cualquier parte, llame al numero gratuito 1-866-375-0775. Representantes de consulta estan disponibles lunes a viernes, de 8:30 am a 5:30 pm (hora del Este), para darle asistencia en espanol.

ILLINOIS REQUIREMENTS

The group insurance policies that provide the insurance benefits of the Benefit Program are issued in Illinois, which requires the following changes to the noted sections.

General Questions:

1. The description of eligible dependents is expanded to include:

   - your unmarried child from age 26 until age 30 provided he or she: (1) is a resident of Illinois; (2) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; and (3) has received a release or discharge other than a dishonorable discharge; and

   - a person of the same or opposite sex with whom you form a civil union according to Illinois law and otherwise eligible children who are born or brought into a civil union that has been established according to Illinois law.

2. The description of when a minor child's coverage begins is changed to read as follows:

   A minor child who, due to a court order or placement for adoption, comes under your care and control while the BasicAdvantage Total Coverage is in force is covered for injury and sickness. The coverage provided to such child will be the same as provided for other members of the Insured's family. The child will be covered from the earlier of the date of the court order or the date of placement in your home if you apply for coverage and pay any required premium within 31 days after the date of the court order or placement. However, coverage will begin at the moment of birth if the court order or placement for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. The carrier reserves the right to approve or disapprove any late application to cover a dependent.

BasicAdvantage Total Coverage:

1. The definition of injury is changed to:

   Injury is a covered person's bodily injury caused by an accident that results, directly and independently of sickness, disease or bodily infirmity, in a covered loss. All injuries sustained in one accident, including all related conditions and recurring symptoms of the injuries, will be considered one injury.

2. The definition of sickness is changed to:

   Sickness is a covered person's illness or disease that is treated by a doctor while coverage is in force.

Term Life Coverage:

1. The accidental death benefit exclusion regarding taking poison, gas, drugs or chemicals is changed to:

   Intentionally taking poison or inhaling gas, or intentionally taking a drug or chemical not administered by a physician;

2. The accidental death benefit exclusion regarding war is changed to:

   War or any act of war, whether declared or not, when accidental death occurs (1) while serving in a civilian non-combatant unit with the military, naval or air forces of any country or combination of countries or international organization or within 6 months after termination of service with such unit, or (2) while not in such units, if the death occurs within 2 years of the date the person is first covered under the policy and the death occurs while outside the home area or within 6 months of returning to the home area. Home area means the 50 states of the United States, District of Columbia, Puerto Rico, Virgin Islands and Canada.

3. The accidental death benefit exclusion regarding the release of nuclear energy does not apply.

4. The accidental death benefit exclusion regarding flying is changed to:

   Your operating or riding in any aircraft other than while a passenger on a licensed, commercial, non-military aircraft; and

Short-Term Disability Coverage:

1. The references to Workers' Compensation or similar law, as found in the exclusion regarding work-related injury or sickness, do not apply.

2. The exclusion regarding taking poison, gas, drugs or chemicals is changed to:

   Intentionally taking poison or inhaling gas, or intentionally taking a drug or chemical not administered by a physician;

3. The exclusion regarding the release of nuclear energy does not apply.

4. The exclusion regarding flying is changed to:

   Your operating or riding in any aircraft other than while a passenger on a licensed, commercial, non-military aircraft; and

DEFINITION OF ELIGBLE EMPLOYEES

In accordance with the regulations implementing the employer-shared responsibility requirements of the Affordable Care Act, the University of Illinois determines eligibility of employees as follows:

1. Employees eligible for coverage on the effective date of coverage under the plan:

   Employees designated as variable-hour employees across University employee classifications (including undergraduate and graduate student employees and other temporary, intermittent, irregular employees, variable hour or contingent faculty, civil service and academic staff) who average at least thirty (30) hours of service per week during a standard twelve (12) month measurement period ending on October 2, 2015.

2. Employees eligible for coverage on the effective date of coverage under the plan or first day of service, whichever is later:

   (a) Employees hired to fill a job vacancy who, as of the date of hire, are expected to average at least 30 hours of service per week.

   (b) Employees holding a J1 or F1 Visa who average at least thirty (30) hours of service per week, but have not met the "substantial presence" test.

3. Employees eligible to participate in an annual open enrollment for coverage effective on the first day of the plan year following that open enrollment period:

   Ongoing employees designated as variable-hour employees across University employee classifications (including undergraduate and graduate student employees and other temporary, intermittent, irregular employees, variable hour or contingent faculty, civil service and academic staff) who average at least thirty (30) hours of service per week during a standard twelve (12) month measurement period ending annually on October 2nd.

4. Employees eligible for coverage upon conclusion of an eleven (11) month initial measurement period:

   New employees designated as variable-hour employees across University employee classifications (including undergraduate and graduate student employees and other temporary, intermittent, irregular employees, variable-hour or contingent faculty, civil service and academic staff) who average at least thirty (30) hours of service per week during an initial eleven (11) month measurement period beginning on the first day of the month following the first day of service:

GENERAL QUESTIONS

Can I change my enrollment choices?
Not usually. Typically you must wait for the next open enrollment period. However, there are certain times when enrollment changes can be made.

For example, if you didn't enroll your dependents in BasicAdvantage Total Coverage because they were already covered under another plan, and that coverage is lost, you can request a special enrollment within 31 days of the loss of that other coverage.

Reasons for losing other medical coverage:
- Divorce, legal separation, or death;
- Termination of a dependent's employment;
- Reduction of a dependent's hours;
- Termination of COBRA rights; or
- Loss of employer's contribution to spouse's medical coverage.

If you have a change in your family situation, such as a divorce, legal separation, death, marriage, or birth/adoption of a child, you can also request a special enrollment within 31 days of that change.

YOU MUST COMPLETE A LIFE EVENT CHANGE FORM to make any enrollment change. That form is available from your Employer.

When will coverage end?
Coverage ends if:
- premiums aren't paid in full;
- you enter an Armed Service on full-time active duty;
- you are no longer eligible for the coverage; or
- the group policies terminate.

If coverage ends, you may be entitled to continue your coverage under COBRA. There is information about COBRA later in this booklet. If you enter full-time active duty in an Armed Service, you may be able to continue your coverage under the Uniformed Services Employment and Re-employment Rights Act (USERRA). There is information about USERRA later in this booklet.

How much does the Benefit Program cost?
The premium due for the Benefit Program varies depending upon the coverage you selected and which family members you cover. You should check your copy of the form you used to enroll to determine the amount due for your coverage.
Note: Premium amounts are subject to change over time.

Who is an eligible dependent?
BasicAdvantage Total, Essential, Dental & Term Life Coverages allow for eligible dependents to be covered. Eligible dependents are:
- your lawful spouse; and
- your eligible children through age 25.

Eligible children include your children by birth, stepchildren, foster children, legally adopted children, children living with you while you are completing adoption procedures, and children for whom coverage has been court-ordered.
Note: If you have a covered child who turns 26 and is disabled and unable to earn a living, they may still be eligible for coverage. You must notify your Employer within 31 days to ensure continued eligibility for that child. Proof of continued eligibility may be required from time to time.

When does coverage begin and end for my dependents?
Your dependents' coverage begins when your coverage begins if you enrolled them when you enrolled. It ends when yours does, or when the dependent is no longer eligible. If you've enrolled in the BasicAdvantage Total Coverage, your child born while coverage is in force is covered for injury and sickness (including covered events that provide necessary care and treatment of congenital defects, birth abnormality and premature birth), as well as routine newborn care for the first 31 days. The child will remain covered for injury and sickness after the first 31 days only if you apply for coverage and pay any required premium within the 31-day period after the child's birth. A minor child who comes under your care and control while the BasicAdvantage Total Coverage is in force is covered for injury and sickness provided you file a petition to adopt. The child will be covered from the date of placement in your home if you apply for coverage and pay any required premium within 31 days after the date of placement. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. The carrier reserves the right to approve or disapprove any late application to cover a dependent.

When does coverage begin and end for my dependents under the Essential Coverage?
Your dependents' coverage begins when your coverage begins if you enrolled them when you enrolled. It ends when yours does, or when the dependent is no longer eligible. If you've enrolled in the Essential Coverage, your child born while coverage is in force is covered for the first 31 days. The child will remain covered for preventive

health services after the first 31 days only if you apply for coverage and pay any required premium within the 31-day period after the child's birth. A minor child who comes under your care and control while the Essential Coverage is in force is covered for preventive health services provided you file a petition to adopt. The child will be covered from the date of placement in your home if you apply for coverage and pay any required premium within 31 days after the date of placement. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. The carrier reserves the right to approve or disapprove any late application to cover a dependent.

If a court order requires that I provide coverage for my dependents, how will this begin?
You and your Employer will both receive the court order requiring coverage to begin for your dependents. Your Employer will then be responsible for making the appropriate arrangements and notifying the carrier.

What if both my spouse and I work for the same Employer?
You can either both choose single coverage or where spouse coverage is available, one of you may choose family coverage. You may not be covered twice. If you and your spouse have one or more eligible children, only one of you may cover all dependents (spouse and children).

COBRA – EXTENDED COVERAGE

What is COBRA?
As noted previously, if your coverage ends you may be entitled to have continued coverage in some circumstances. A federal law known as COBRA gives you this continuation right. It stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. The continuation right only extends to BasicAdvantage Total Coverage, Essential Coverage and Dental Coverage. The employee must be enrolled in the specific coverage(s) in order for it to be continued. For example, if you are enrolled in the BasicAdvantage Total Coverage and Dental Coverage, you may continue both Coverages.

While you may elect COBRA continuation coverage on behalf of your dependents, each person who was covered at the time coverage ends has his or her own right to elect COBRA and/or any other state continuation or conversion rights. This means that your dependents may elect such coverage even if you decide not to. So, if you have enrolled your eligible spouse or children, please share this information with them. If you would like additional copies of this booklet to share with your spouse or children, please contact your Employer. For more information about your COBRA rights, contact your Employer.

When am I eligible for COBRA?
You and your covered dependents are eligible for COBRA continuation if your coverage ends because you quit or lose your job for any reason, other than gross misconduct, or your hours are reduced. Generally, you and your dependents are entitled to continue health coverage for 18 months. However, if you or your dependents are disabled, then the period may be extended to a total term of 29 months (see "What if I am disabled when my employment ends?").

What about my dependents?
Your dependents are also eligible for COBRA continuation if they lose coverage at any time due to:
- your death;
- your divorce or legal separation;
- your becoming entitled to Medicare while on COBRA; or
- your dependent no longer meeting the eligibility definition under the Benefit Program (for example, a dependent child reaching the age limit).

In any of these qualifying events your dependents are entitled to continue health coverage for 36 months from the date of the event.

What must I do to elect COBRA?
Your Employer must provide notice when you lose or quit your job, your hours are reduced, or you become entitled to Medicare. Your Employer will notify you of your right to elect COBRA by sending you a COBRA election notice. Within 60 days of that notification, you must respond, in writing, of your election.

Do my dependents and I have to keep my Employer informed?
Yes. You and your dependents must notify your Employer of your current address and, if different, the address(es) of your dependents (spouse and children). You and/or your dependents must provide notice of: (1) your divorce or legal separation; (2) your dependent's loss of coverage for any of the reasons previously listed (see "What about my dependents?"); and (3) a determination by the Social Security Administration that you or your covered dependents are disabled. You and your dependents must mail or hand-deliver written notice of these events within 60 days to your Employer.

When does COBRA end?
COBRA coverage will end on the earliest of:
- the expiration of the maximum allowable term of 18, 29 or 36 months;
- the date the required premium is not paid when due;
- the date the group health coverage is terminated for active employees;

- the date the person on COBRA coverage first becomes covered under any other group health plan, without limitation as to any pre-existing condition that affects coverage; or
- the date the person on COBRA coverage becomes entitled to Medicare benefits.

What if I am on extended sick leave when my employment ends?
Under the federal Family and Medical Leave Act of 1993 (FMLA), you may be entitled to extended sick leave from your employment. If during that period you do not pay your premium, you can still elect COBRA if your employment ends during your FMLA leave. In such a case, you would not have to make up the missed premium for any time when you were on FMLA leave, but you would not be covered for any gaps in coverage.

What if I am disabled when my employment ends?
In order to extend continuation coverage for you and your dependents to 29 months, you or a covered family member must be disabled before or within the first 60 days of COBRA coverage. If this is the case, a copy of the Social Security Administration's "determination of disability" must be sent to your Employer within 60 days of the determination, and within the original 18 months of your COBRA coverage. The premium to be paid for this additional 11 months of coverage may be substantially greater than the premium for the initial 18-month period and you will be notified of the additional cost of the extended coverage. If, during the 11-month extension, you or your covered dependents are no longer disabled, you must notify your Employer within 30 days. The extended COBRA coverage will end when you or your dependent are no longer disabled.

Is there another way to extend COBRA coverage?
Yes. If, while under the initial 18-month COBRA continuation coverage, your covered dependents experience another event that separately entitled them to COBRA continuation, they may get up to 18 additional months of continuation coverage. Notice of the second qualifying event must be given to your Employer. This extension is available only if the event would have caused the dependent to lose coverage under the Benefit Program had the first loss of coverage not occurred.

When will I pay for COBRA coverage?
Your COBRA election notice identifies premium amounts due for your election(s). You may submit a premium payment when you return your COBRA election notice. If you do, you will be sent payment coupons for future COBRA premium payments.

If you do not pay your premium with your COBRA election notice, you must make your first premium payment within 45 days from the date of your election. After your initial premium payment, you must pay the regular monthly payments (shown on your COBRA election notice) by the first of each month. A monthly bill will not be sent to you.

What premium has to be paid for COBRA coverage?
Generally, you will pay the rate for similarly situated active employees under the Benefit Program, plus a 2% administrative fee. If the rate changes for active employees, your rate will change accordingly. As noted above, the premium for the 11-month extension because of disability could be substantially higher than normal.

What rights does a person on COBRA have during an open enrollment period?
A person on COBRA has the same rights at open enrollment as other covered persons under the Benefit Program.

Is there a way, other than COBRA, to extend coverage?
In some limited circumstances, and as governed by state law, you may be entitled to extended coverage if you lose your coverage and do not elect COBRA. At such time, you should contact your Employer to determine what rights, if any, you might have.

Are there any other insurance options available after coverage under this program terminates?
There may be other health insurance options available to you and your family. You are also able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

ABOUT THE BENEFIT PROGRAM

CONFORMITY WITH THE LAW
If any provision of the Benefit Program is contrary to any law to which it is subject, such provision is hereby amended to conform thereto. Nothing in the Benefit Program is intended to replace or affect any requirements for coverage by Workers' Compensation insurance.

BENEFIT PROGRAM TERMINATION, AMENDMENT, AND ADMINISTRATION
The Employer intends to continue the Benefit Program but reserves the right at any time, at its discretion, to terminate the Benefit Program, to modify the Benefit Program, to provide different cost-sharing between the Employer and participants, or to amend the Benefit Program in any respect. In the event the Benefit Program is terminated, any assets held in trust for the Benefit Program will be used to provide welfare benefits for employees

of the Plan Sponsor or a successor, or they will be used in other ways not prohibited by the Internal Revenue Service regulations.

UNIFORMED SERVICES EMPLOYMENT and RE-EMPLOYMENT RIGHTS ACT (USERRA)

A federal law known as USERRA requires an Employer to offer continuation of coverage when an enrolled employee is called to serve in the military. The continuation right only extends to BasicAdvantage Total Coverage, Essential Coverage and Dental Coverage. The employee must be enrolled in the specific coverage(s) in order for it to be continued. For example, if you are enrolled in the BasicAdvantage Total Coverage and Dental Coverage, you may continue both Coverages.

If you are called to military duty for more than 30 days, you may elect to continue coverage for you and your covered dependents for up to 24 months, but you may be required to pay up to 102% of the premium for your coverage. Your Employer is required to provide coverage for you as though you had remained on the job if you are out on military service for less than 31 days. In this case, you will be charged only your share of the premium. When you return to work, your coverage will be reinstated with no new waiting periods.

PLAN DESCRIPTION

This booklet, together with the copy you made of the form you used to enroll, is a Plan Description. It provides a summary of the major provisions and benefits of the Benefit Program. It is also intended to tell you about the limitations and exclusions of the Benefit Program. Because this booklet is only a summary, it has not been written with all of the technical words and legal phrases used in the official Benefit Program documents. For full details about the insurance coverage, you may obtain a copy of the policy(ies) from the Employer. The official Benefit Program documents remain the final authority and, in the event of a conflict with this booklet, shall govern in all cases.

ASRM

ASRM is a Third Party Administrator that provides records keeping and claims paying services for the carrier identified under "BENEFIT PROGRAM INFORMATION". The carrier is the underwriter of the insurance contract(s). As a Third Party Administrator, ASRM has no discretionary powers under the Benefit Program and, in particular, has no discretionary power in the paying or denying of claims. ASRM is referred to as "RSL Specialty Products Administration" throughout this booklet.

PROGRAM FUNDING

Benefits will be provided on a fully-insured basis through the insurance contract(s) issued by the carrier directly to the Plan Sponsor. Participants are responsible for all required premiums, less any Employer contribution. The carrier provides certain policyholder and claims processing through ASRM (see above). The carrier serves as the claims review fiduciary with respect to the insurance contract(s) and the Benefit Program. The claims review fiduciary has the discretionary authority to interpret the Benefit Program and the insurance contract(s) and to determine eligibility for benefits. Decisions by the claims review fiduciary are complete, final and binding on all parties.

BASICADVANTAGE TOTAL COVERAGE

INPATIENT BENEFITS

What are the hospital daily room & board benefits?
The Coverage pays a hospital confinement daily benefit amount for each day a covered person is confined to a hospital as an inpatient. The daily benefit amount and maximum number of daily benefits vary based on the condition being treated.

Hospital confinement daily benefit amounts and per person maximums are:

Treatment of Mental & Nervous Conditions: $100 per day; maximum of 25 daily benefits per coverage year
Treatment of Alcohol & Substance Abuse: $100 per day; maximum of 25 daily benefits per coverage year
Treatment of All Other Covered Conditions: $200 per day; maximum of 90 daily benefits per coverage year

Are there any restrictions on the number of hospital days that can be covered for childbirth admissions?
The Coverage does not restrict the covered person's doctor in authorizing the length of stay that is appropriate. The hospital confinement daily benefits payable for childbirth are subject to the same maximum number of days that applies with respect to a hospital stay for All Other Covered Conditions.

Are inpatient surgeries covered?
Yes. The Coverage pays a daily benefit based on the specific surgical procedure performed for each inpatient surgery. The inpatient surgical benefit ranges from $9 to $500; see the Sample Inpatient Surgical Schedule later in this Coverage section.

Is reconstructive surgery following a mastectomy covered?
Yes. A covered person who has a mastectomy is covered for reconstructive breast surgery.

Is anesthesia administered during an inpatient surgery covered?
Yes. Each day a covered person has anesthesia administered during covered inpatient surgery, the Coverage pays a daily benefit of 20% of the benefit paid for the corresponding surgical procedure.

What is the hospital admission benefit?
The Coverage pays a single daily benefit when a covered person is admitted as an inpatient to the hospital for treatment of any of the covered conditions shown below. The daily benefit amount varies by condition and is payable based on the first diagnosis code listed on the claim form for the hospital admission. See the list of Covered Diagnosis Codes later in this booklet.

When the first listed diagnosis code indicates the admission is for treatment of a covered condition, the applicable hospital admission daily benefit amounts and per person maximums are:

Cancer:	$2,000 per day; maximum of 1 daily benefit per coverage year
Injury:	$1,000 per day; maximum of 1 daily benefit per coverage year
Stroke:	$1,000 per day; maximum of 1 daily benefit per coverage year
Childbirth:	$1,000 per day; maximum of 1 daily benefit per coverage year
Heart Attack:	$1,500 per day; or
Heart Disease:	$1,000 per day; the hospital admission daily benefit is payable for either Heart Attack or Heart Disease, but not both, subject to a maximum of 1 daily benefit per coverage year for both conditions.

Are inpatient events that are not specifically described in the benefits covered?
No. Only inpatient hospital confinements and events that are described and categorized as inpatient surgical procedures and administration of anesthesia are covered. Other events, such as inpatient doctors' visits and private-duty nursing, are not covered under the Coverage and there is no benefit for these types of events.

OUTPATIENT BENEFITS

What are the benefits for outpatient doctors' visits?
The Coverage pays a daily benefit for each day a covered person visits a doctor as an outpatient. The daily benefit amount and maximum number of daily benefits vary based on the type of visit. Outpatient doctors' visits daily benefit amounts and per person maximums are:

New patient office visit:	$75 per day; maximum of 1 daily benefit per coverage year
Established patient office visit:	$60 per day; maximum of 3 daily benefits per coverage year
Consultation office visit:	$75 per day; maximum of 1 daily benefit per coverage year
Emergency Room doctor visit:	$50 per day; maximum of 1 daily benefit per coverage year

What are the outpatient radiology benefits?
The Coverage pays a daily benefit for each day a covered person has outpatient diagnostic radiology services. The daily benefit amount and maximum number of daily benefits vary based on the type of diagnostic radiology service. The Coverage will not pay more than 1 outpatient radiology daily benefit per day for each covered person. Outpatient radiology daily benefit amounts and per person maximums are:

Magnetic Resonance Imaging (MRI): $100 per day; maximum of 1 daily benefit per coverage year

Computerized Tomography (CT) Scan: $50 per day; maximum of 1 daily benefit per coverage year
All other radiology services: $40 per day; maximum of 3 daily benefits per coverage year

Note: If these services occur as part of an emergency room visit, they are NOT covered under this benefit. See "What if I use an emergency room?" below.

Are outpatient pathology services covered?
Yes. The Coverage pays $40 for each day a covered person has outpatient diagnostic pathology services, subject to a per person maximum of 3 daily benefits each coverage year. The Coverage will not pay more than 1 outpatient pathology daily benefit per day for each covered person.
Note: If these services occur as part of an emergency room visit, they are NOT covered under this benefit. See "What if I use an emergency room?" below.

Are visits to an urgent care facility covered?
Yes. The Coverage pays a daily benefit of $50 for each day a covered person visits an urgent care facility and receives treatment, subject to a per person maximum of 1 daily benefit each coverage year.

Are outpatient surgeries covered?
Yes. The Coverage pays a daily benefit based on the specific surgical procedure performed for each outpatient surgery. The outpatient surgical benefit ranges from $14 to $500; see the Sample Outpatient Surgical Schedule later in this Coverage section.
Note: If your outpatient surgery is performed as part of an emergency room visit, it is NOT covered under this benefit. See "What if I use an emergency room?" below.

Is anesthesia administered during an outpatient surgery covered?
Yes. Each day a covered person has anesthesia administered during covered outpatient surgery, the Coverage pays a daily benefit of 20% of the benefit paid for the corresponding surgical procedure.
Note: If you receive anesthesia during an outpatient surgery performed as part of an emergency room visit, it is NOT covered under this benefit. See "What if I use an emergency room?" below.

What if I use an emergency room?
The Coverage pays a daily benefit of $500 for each day a covered person goes to a hospital emergency room for the treatment of an injury, subject to a per person maximum of 2 daily benefits each coverage year; and a daily benefit of $50 for each day a covered person goes to a hospital emergency room for the treatment of a sickness, subject to a per person maximum of 3 daily benefits each coverage year. The Coverage will not pay more than 1 emergency room daily benefit per day for each covered person.

Are outpatient events that are not specifically described in the benefits covered?
No. Only the types of events that are described and categorized as outpatient doctors' visits, outpatient diagnostic radiology and pathology services, outpatient surgery and administration of anesthesia, emergency room visits, and outpatient prescription drug purchases are covered. Other events, such as injections and durable medical equipment, are not covered under the Coverage and there is no benefit for these types of events.

PRESCRIPTION DRUG BENEFITS

Is there a benefit for outpatient prescription drugs?
Yes. The Coverage pays a daily benefit of $25 for each day a covered person has a generic drug prescription filled or refilled by a pharmacist. Benefits for generic drugs are subject to a per person maximum of 7 daily benefits each coverage year.

Can I use any pharmacy?
Yes, but you can use the Prescription Drug ID Card received with the BasicAdvantage Total Coverage to help save money at a pharmacy that participates in the Express Scripts, Inc. network.

How does the Prescription Drug ID Card work?
Most pharmacies participate in the Express Scripts, Inc. network, but you should check with the pharmacy before you make your purchase or call Express Scripts, Inc. at 1-866-282-1491 for providers in your area. Participating pharmacies provide discounts of up to 15% on all prescriptions when you present your card. You will not have to file a claim on purchases made at participating pharmacies. The pharmacist will tell you exactly what to pay.

What if I use a non-participating pharmacy?
You must pay the full price up front. Then you must call Express Scripts, Inc. at 1-866-282-1491 and request a claim form. File the claim with Express Scripts, Inc. Do not file your prescription drug claims with RSL Specialty Products Administration.

Are there other ways that I can lower the cost of my prescriptions?
If you take a generic medication on a regular basis, a mail order service is available that may provide an even larger discount. You may visit Express Scripts, Inc. at their website www.express-scripts.com or call Express Scripts, Inc. at 1-866-282-1491 for more information.

What if I have a prescription from my dentist?
You may only purchase medical prescriptions, except when the prescription is issued in connection with covered dental treatment for an accident covered under your BasicAdvantage Total Coverage.

COMMONLY USED TERMS

What is the "coverage year"?
It is the period of time during which benefit maximums accumulate. Each new coverage year, the maximums are reset. You will find the coverage year under "BENEFIT PROGRAM INFORMATION". The coverage year should not be confused with the ERISA Plan Fiscal Year End.

What are "covered events"?
The Coverage usually covers events that are for the treatment of injury and sickness. These events must be medically necessary, occur while the Coverage is still in force, and not excluded.

What is a "hospital"?
A hospital is an institution operated by law for the care and treatment of injured or sick persons that has organized facilities for diagnosis and surgery (or has a contract with another hospital for these services), and has 24-hour nursing service. A hospital is not an institution that is primarily a rest, nursing or convalescent home, a home for the aged, an alcoholism or drug addiction treatment facility, or a facility for treatment of mental disorders.

What does "injury" mean?
Injury is a covered person's bodily injury caused by an accident that results, directly and independently of all other causes, in a covered loss. All injuries sustained in one accident, including all related conditions and recurring symptoms of the injuries, will be considered one injury.

What are "inpatient" events?
Inpatient events are those that occur at licensed hospital facilities when you are admitted as an inpatient and charged for at least one day's room & board.

What are "outpatient" events?
Outpatient events are those that occur at doctors' offices, free-standing clinics, and hospitals when you are not admitted as an inpatient.

What does "sickness" mean?
Sickness is a covered person's sickness or disease that results, directly and independently of all other causes, in a covered loss.

EXCLUSIONS AND LIMITATIONS

No benefits will be paid for loss caused by or resulting from:

- Outpatient treatment of mental or nervous conditions;
- Outpatient treatment of alcoholism or substance abuse;
- Intentionally self-inflicted injuries, suicide, or any attempt thereat while sane or insane;
- Acts of declared or undeclared war;
- The covered person's commission of a felony;
- Work-related injury or sickness;
- Normal health checkups;
- Eye examinations for glasses, any kind of eye glasses, or prescriptions therefore;
- Hearing examinations, or hearing aids;
- Dental care, treatment or supplies except covered events rendered in connection with the care of sound, natural teeth and gums required on account of accidental injury that happens while covered, and rendered within 6 months of the accident;
- Reading or interpreting the results of any diagnostic pathology or radiology tests;
- Care, treatment or supplies rendered in connection with cosmetic surgery, except covered events rendered in connection with surgery needed for breast reconstruction following a mastectomy or an accident that happens while covered under the BasicAdvantage Total Coverage. The surgery needed for an accident must be performed within 90 days of the accident;
- Brand name drugs and drugs not requiring a prescription;
- Care, treatment or supplies rendered while outside the United States of America; and
- Care, treatment or supplies rendered by an immediate family member or by the ERISA Plan Sponsor.

IMPORTANT NOTE: Your BasicAdvantage Total Coverage allows access to important medical provider and pharmacy provider networks that utilize negotiated charges which may save you money. You may contact MultiPlan (at 1-800-877-0005) or Express Scripts (at 1-866-282-1491) to find network providers in your area.

NON-INSURANCE BENEFITS

Your BasicAdvantage Total Coverage allows access to important non-insurance benefits as described below. The suppliers of these plans are not affiliated with the carrier, which is not responsible for the content of the plans and cannot be held liable for any services provided or not provided by these suppliers.

What does membership in the Broadreach Medical Resources (BMR) Telemedicine and Teletherapy plan give me?
Membership in the BMR Telehealth and Teletherapy plan is a separate benefit that you receive when you are enrolled in the BasicAdvantage Total Coverage. This benefit offers you the ability to talk or video chat with a doctor or licensed therapist and counsellor from the comfort and privacy of your own home or office. The service is not insurance and no referrals or approvals are ever needed to access plan benefits.

The benefits include:

- 24/7/365 Toll-free, confidential availability to talk or video chat access with licensed healthcare providers;
- On-line scheduling of 50-minute behavioral health sessions with licensed therapists, social workers and counselors;
- Medical diagnosis and personalized treatment for common illnesses and injuries;
- Lab test results reviewed;
- Medically necessary e-prescriptions (where permitted) delivered to a pharmacy of your choice;

To use this benefit, you may:

- Call toll-free 1-833-936-9633;
- Visit and login to RSL.YourBMRBenefits.com and enter the Group Validation Code (GVC): RSL2020;
- Use the free Apple iOS app which may be downloaded from the app store or use your camera to scan the QR Code and enter the Group Validation Code (GVC): RSL2020; or

- If you are using an Android device, go to the Google Play store and search 'Broadreach Medical Resources' or use your camera to scan the QR Code and enter the Group Validation Code (GVC): RSL2020.

If you need assistance with enrollment, validation or have general App and web usage questions related to the BMR Telemedicine and Teletherapy plan, please call 866-718-2375 or email care@bmr-inc.com.

What do Telemedicine and Teletherapy services cost?
Telehealth services are available after a $28 per-consultation fee has been paid. Teletherapy services are available after a $69 per-consultation fee has been paid. Credit card payment is required in order to access these benefits.

What does membership in the On Call Travel Assistance Plan give me?
Membership in the On Call Travel Assistance Plan is a separate benefit that you receive when you are enrolled in the BasicAdvantage Total Coverage. This benefit offers a 24-hour, toll-free service that provides a comprehensive range of information, referral, coordination and arrangement services designed to respond to most medical care situations and many other emergencies you may encounter when you travel. This benefit also provides pre-trip assistance, including passport/visa requirements, foreign currency and weather information. All services under this benefit are provided by On Call International (On Call).

When traveling more than 100 miles from home or in a foreign country, the following services are offered:

Pre-Trip Assistance
- Inoculation requirements information
- Passport/visa requirements
- Currency exchange rates
- Consulate/embassy referral
- Health hazard advisory
- Weather information

Emergency Personal Services
- Urgent message relay
- Interpretation/translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage/personal possessions
- Legal assistance and/or bail

Emergency Medical Transportation*
- Emergency evacuation
- Medically necessary repatriation
- Visit by family member or friend
- Return of traveling companion
- Return of dependent children
- Return of vehicle
- Return of mortal remains

Medical Services Include:
- Medical referrals for local physicians/dentists
- Medical case monitoring
- Prescription assistance and eyeglass replacement
- Convalescence arrangements

*Emergency Medical Transportation services are subject to a maximum combined single limit of $250,000. Return of vehicle is subject to $2,500 maximum limit.

To use this benefit at any time before or during a trip, you may contact On Call for emergency assistance services. In the U.S., call toll-free at 1-800-456-3893. Worldwide, call collect at 1-603-328-1966

What does membership in the VSP Access Plan give me?
Membership in the VSP Access Plan is a separate benefit that you receive when you are enrolled in the BasicAdvantage Total Coverage. This benefit, which is provided through Vision Service Plan, offers discounts on eye exams and prescription glasses from VSP network doctors. When you visit a network doctor, you can receive a 20% discount on your eye exam, a 15% discount on your contact lens exam, a 20% discount on your frame, lenses and lens options when a complete pair of prescription glasses is purchased. You also can receive discounts on laser vision correction. The discounts for prescription glasses and contact lenses are only available from the VSP network doctor who provided your eye exam within the past 12 months. For questions regarding the VSP Access Plan, call VSP at 1-800-877-7195 or visit their website at www.vsp.com.

SAMPLE SURGICAL SCHEDULES
Below are sample inpatient and outpatient surgical schedules. The schedules list many common surgeries and their corresponding daily benefit amounts. The daily benefit amounts are based on the relative value assigned to the particular surgical procedure in the 2011 National Physician Fee Schedule Relative Value File published by the Centers for Medicare and Medicaid Services (CMS).

The Coverage will also cover a surgical procedure that is not listed in the sample schedules, as long as the procedure is classified as a surgery in the CMS. The daily benefit amount for a surgical procedure that is not listed in the sample schedules will be consistent with the other daily benefit amounts shown in the sample schedules.

Sample Inpatient Surgical Schedule
$500 Maximum Benefit

CPT Code	Description	Benefit Amount
	Integumentary System	
17000	Destroy Benign or Premalignant Lesion	$117
17003	Destroy Benign or Premalignant Lesions 2-14	$9
19305	Radical Mastectomy	$500
	Musculoskeletal System	
20937	Spinal Bone Autograft	$356
22554	Neck Spine Fusion	$500
22585	Additional Spinal Fusion	$500
22612	Lumbar Spine Fusion	$500
22845	Insert Spine Fixation Device	$500
27130	Total Hip Arthroplasty	$500
27447	Total Knee Arthroplasty	$500
	Respiratory System	
31500	Insert Emergency Airway	$230
31622	Diagnostic Bronchoscopy	$307
32551	Insertion of Chest Tube	$357
	Cardiovascular System	
33518	Coronary Artery Bypass, Two Venous Grafts	$500
33519	Coronary Artery Bypass, Three Venous Grafts	$500
33533	Coronary Artery Bypass, Single Arterial Graft	$500
33534	Coronary Artery Bypass, Two Arterial Grafts	$500
35301	Rechanneling of Artery	$500
36010	Place Catheter in Vein	$256
36216	Place Catheter in Artery	$500
	Digestive System	
43235	Upper Gastrointestinal Endoscopy	$306
43239	Upper Gastrointestinal Endoscopy, Biopsy	$361
43280	Laparoscopy, Fundoplasty	$500
44140	Partial Removal of the Colon	$500
44950	Appendectomy	$500
44970	Laparoscopy, Appendectomy	$500
45378	Diagnostic Colonoscopy	$458
45380	Colonoscopy and Biopsy	$500
47562	Laparoscopic Cholecystectomy	$500
47563	Cholecystectomy with Cholangiography	$500
49000	Exploration of the Abdomen	$500
49568	Hernia Repair with Mesh	$500
	Urinary System	
51840	Attach Bladder/Urethra	$500
52332	Cystoscopy and Treatment	$298
	Male/Female Genital System	
55845	Extensive Prostate Surgery	$500
57260	Repair of Vagina	$500

58100	Biopsy of Uterus Lining	$186
58150	Total Hysterectomy	$500
58260	Vaginal Hysterectomy	$500
58262	Vaginal Hysterectomy with Removal of Tube(s) and/or Ovary(s)	$500
58340	Catheter for Hysterography	$120
58550	Laparoscopy, Surgical with Vaginal Hysterectomy	$500
58720	Removal of Ovary/Tube(s)	$500
	Maternity Care and Delivery	
59120	Surgical Treatment of an Ectopic Pregnancy	$500
59400	Routine Obstetric Care including Vaginal Delivery and Antepartum & Postpartum Care	$500
59510	Routine Obstetric Care including Cesarean Delivery and Antepartum & Postpartum Care	$500
	Nervous System	
63030	Low Back Disk Surgery	$500
63050	Cervical Laminoplasty	$500
63048	Lumbar Laminectomy, each Additional Segment	$452
63075	Neck Spine Disk Surgery	$500

Sample Outpatient Surgical Schedule
$500 Maximum Benefit

CPT Code	Description	Benefit Amount
	Integumentary System	
10021	Fine Needle Aspiration without Imaging	$298
10040	Acne Surgery	$212
10120	Incision and Removal of Foreign Body	$284
10160	Puncture Drainage of Lesion	$263
11400	Removal of Skin Lesion	$246
11730	Removal of Nail Plate	$198
12001	Repair Superficial Wound(s)	$174
15845	Skin and Muscle Repair Face	$500
17000	Destroy Benign or Premalignant Lesions	$165
17003	Destroy Benign or Premalignant Lesions 2-14	$14
	Musculoskeletal System	
20550	Injection; Tendon Sheath, Ligament, Ganglion Cyst	$118
20610	Arthrocentesis, Aspiration of Major Joint or Bursa	$164
22548	Neck Spine Fusion	$500
25600	Closed Treatment of Distal Radial Fracture	$500
29075	Application of a Forearm Cast	$181
29125	Application of a Forearm Splint	$141
29405	Application of a Short Leg Cast	$181
29877	Knee Arthroscopy	$500
	Respiratory System	
30520	Repair of Nasal Septum	$500
31231	Nasal Endoscopy, Diagnostic	$398
31575	Diagnostic Laryngoscopy	$239
	Digestive System	
42820	Tonsillectomy and Adenoidectomy	$500
43235	Upper Gastrointestinal Endoscopy	$500
43239	Upper Gastrointestinal Endoscopy with Biopsy	$500
45330	Diagnostic Sigmoidoscopy	$281
45355	Surgical Colonoscopy	$433
45380	Colonoscopy and Biopsy	$500
45384	Colonoscopy with Removal of Tumor(s), Polyp(s)	$500
46600	Diagnostic Anoscopy	$174
47562	Laparoscopic Cholecystectomy	$500
49505	Repair Initial Inguinal Hernia, age 5 or over	$500
	Urinary System	
50590	Fragmenting of Kidney Stone	$500
51701	Insert Bladder Catheter	$108
51820	Revision of Urinary Tract	$500
52000	Cystoscopy	$403
52317	Remove Bladder Stone	$500
52330	Cystoscopy and Treatment	$500
	Male/Female Genital System	
55700	Biopsy of the Prostate	$433
57452	Colposcopy	$224

57454	Colposcopy with Biopsy	$320
57511	Cryocautery of the Cervix	$301
58100	Biopsy of Uterus Lining	$227
58120	Dilation and Curettage	$500
58558	Hysteroscopy with Biopsy	$500
58662	Laparoscopy with Excision of Lesions	$500
	Nervous System	
64450	Injection, Anesthetic Agent, Peripheral Nerve or Branch	$217
64721	Carpal Tunnel Surgery	$500
	Eye and Ocular Adnexa System	
65222	Remove Foreign Body from the Eye	$158
66984	Removal of Cataracts, Stage One Procedure	$500
68761	Close Tear Duct Opening	$300
69210	Removal of Impacted Ear Wax	$107
69436	Create Eardrum Opening	$344

COVERED DIAGNOSIS CODES

The hospital admission daily benefit varies based on the first diagnosis code listed on the claim form for the hospital admission, which will be an ICD-10 code. All ICD-10 diagnosis codes for which a benefit is payable are shown below. (All subcodes within a major code are included unless otherwise noted.)

Covered Diagnosis Codes

Description	ICD-10 Code
Accidental Injury (does not include poisoning)	
FRACTURES	S02.0xxA – T14.8
DISLOCATIONS	S03.0xxA – M99.10
SPRAINS AND STRAINS OF JOINTS AND ADJACENT MUSCLES	S43.50xA – S03.1xxA
INTRACRANIAL INJURY, EXCLUDING THOSE WITH SKULL FRACTURE	S06.0x0A – S06.891A
INTERNAL INJURY OF THORAX, ABDOMEN, AND PELVIS	S27.0xxA – S36.90xA
OPEN WOUND	S01.111A – S88.111A
INJURY TO BLOOD VESSELS	S15.009A – S75.001A
SUPERFICIAL INJURY	S00.01xA – T07
CONTUSION WITH INTACT SKIN SURFACE (EXCLUDING 922.33)	S00.03xA – S70.10xA
CRUSHING INJURY	S07.0xxA – S77.20xA
EFFECTS OF FOREIGN BODY ENTERING THROUGH ORIFICE	T15.00xA – T19.0xxA
BURNS	T26.50xA – T30.0
INJURY TO NERVES AND SPINAL CORD	S04.011A – S14.4xxA
CERTAIN TRAUMATIC COMPLICATIONS AND UNSPECIFIED INJURIES	T79.0xxA – S09.10xA

Description	ICD-10 Code
Cancer (Malignant Neoplasm)	
MALIGNANT NEOPLASM OF LIP	C00.0
MALIGNANT NEOPLASM OF TONGUE	C02.0
MALIGNANT NEOPLASM OF MAJOR SALIVARY GLANDS	C07
MALIGNANT NEOPLASM OF GUM	C03.0
MALIGNANT NEOPLASM FLOOR OF MOUTH	C04.0
MALIGNANT NEOPLASM OTHER & UNSPECIFIED PARTS OF MOUTH	C06.0
MALIGNANT NEOPLASM OF OROPHARYNX	C09.8
MALIGNANT NEOPLASM OF NASOPHARYNX	C11.0
MALIGNANT NEOPLASM OF HYPOPHARYNX	C13.0
MALIGNANT NEOPLASM OF OTHER AND ILL-DEFINED SITES WITHIN THE LIP, ORAL CAVITY, AND PHARYNX	C14.0
MALIGNANT NEOPLASM OF ESOPHAGUS	C15.3
MALIGNANT NEOPLASM OF STOMACH	C16.0
MALIGNANT NEOPLASM OFSMALL INTESTINE, INCLUDING DUODENUM	C17.0
MALIGNANT NEOPLASM OF COLON	C18.3
MALIGNANT NEOPLASM OF RECTUM, RECTOSIGMOID JUNCTION & ANUS	C19
MALIGNANT NEOPLASM OF LIVER & INTRAHEPATIC BILE DUCTS	C22.0
MALIGNANT NEOPLASM OFGALLBLADDER & EXTRAHEPATIC BILE DUCTS	C23
MALIGNANT NEOPLASM OF PANCREAS	C25.0
MALIGNANT NEOPLASM OF RETROPERITONEUM & PERITONEUM	C48.0
MALIGNANT NEOPLASM OF OTHER AND ILL-DEFINED SITES WITHIN THE DIGESTIVE ORGANS AND PERITONEUM	C26.0
MALIGNANT NEOPLASM OF NASAL CAVITIES, MIDDLE EAR & ACCESSORY SINUSES	C30.0
MALIGNANT NEOPLASM OF LARYNX	C32.0
MALIGNANT NEOPLASM OF TRACHEA, BRONCHUS, & LUNG	C33
MALIGNANT NEOPLASM OF PLEURA	C38.4
MALIGNANT NEOPLASM OF THYMUS, HEART, & MEDIASTINUM	C37
MALIGNANT NEOPLASM OF OTHER AND ILL-DEFINED SITES IN THE RESPIRATORY SYSTEM & INTRATHORACIC ORGANS	C39.0
MALIGNANT NEOPLASM OF BONE AND ARTICULAR CARTILAGE	C41.0
MALIGNANT NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE	C47.0
MALIGNANT MELANOMA OF SKIN	C43.0
OTHER MALIGNANT NEOPLASM OF SKIN	C44.0
MALIGNANT NEOPLASM OF FEMALE BREAST	C50.011

MALIGNANT NEOPLASM OF MALE BREAST	C50.021
KAPOSI'S SARCOMA	C46.0
MALIGNANT NEOPLASM OF UTERUS, PART UNSPECIFIED	C55
MALIGNANT NEOPLASM OF CERVIX UTERI	C53.0
MALIGNANT NEOPLASM OF PLACENTA	C58
MALIGNANT NEOPLASM OF BODY OF UTERUS	C54.1
MALIGNANT NEOPLASM OF OVARY AND OTHER UTERINE ADNEXA	C56.1
MALIGNANT NEOPLASM OF OTHER AND UNSPECIFIED FEMALE GENITAL ORGANS	C52
MALIGNANT NEOPLASM OF PROSTATE	C61
MALIGNANT NEOPLASM OF TESTIS	C62.00
MALIGNANT NEOPLASM OF PENIS AND OTHER MALE GENITAL ORGANS	C60.0
MALIGNANT NEOPLASM OF BLADDER	C67.0
MALIGNANT NEOPLASM OF KIDNEY AND OTHER AND UNSPECIFIED URINARY ORGANS	C64.1
MALIGNANT NEOPLASM OF EYE	C69.40
MALIGNANT NEOPLASM OF BRAIN	C71.0
MALIGNANT NEOPLASM OF OTHER AND UNSPECIFIED PARTS OF NERVOUS SYSTEM	C72.20
MALIGNANT NEOPLASM OF THYROID GLAND	C73
MALIGNANT NEOPLASM OF OTHER ENDOCRINE GLANDS AND RELATED STRUCTURES	C74.00
MALIGNANT NEOPLASM OF OTHER AND ILL-DEFINED SITES	C76.0
SECONDARY AND UNSPECIFIED MALIGNANT NEOPLASM OF LYMPH NODES	C77.0
SECONDARY MALIGNANT NEOPLASM OF RESPIRATORY AND DIGESTIVE SYSTEMS	C78.00
SECONDARY MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES	C79.00
MALIGNANT NEOPLASM WITHOUT SPECIFICATION OF SITE	C80.0
LYMPHOSARCOMA AND RETICULOSARCOMA AND OTHER SPECIFIED MALIGNANT TUMORS OF LYMPHATIC TISSUE	C83.30
HODGKIN'S DISEASE	C81.70
OTHER MALIGNANT NEOPLASMS OF LYMPHOID AND HISTIOCYTIC TISSUE	C82.00
MULTIPLE MYELOMA AND IMMUNOPROLIFERATIVE NEOPLASMS	C90.00
LYMPHOID LEUKEMIA	C91.00
MYELOID LEUKEMIA	C92.00
MONOCYTIC LEUKEMIA	C93.00
OTHER SPECIFIED LEUKEMIA	C94.00
LEUKEMIA OF UNSPECIFIED CELL TYPE	C95.00
CARCINOMA IN SITU OF DIGESTIVE ORGANS	D00.00
CARCINOMA IN SITU OF RESPIRATORY SYSTEM	D02.0
CARCINOMA IN SITU OF SKIN	D04.00
CARCINOMA IN SITU OF BREASTAND GENITOURINARY SYSTEM	D05.00
CARCINOMA IN SITU OFOTHER AND UNSPECIFIED SITES	D09.20
NEOPLASM OF UNCERTAIN BEHAVIOR OF DIGESTIVE AND RESPIRATORY SYSTEMS	D37.030
NEOPLASM OF UNCERTAIN BEHAVIOR OF GENITOURINARY ORGANS	D39.0
NEOPLASM OF UNCERTAIN BEHAVIOR OF ENDOCRINE GLANDS AND NERVOUS SYSTEMS	D44.3
NEOPLASM OF UNCERTAIN BEHAVIOR OF OTHER AND UNSPECIFIED SITES AND TISSUES	D48.0
NEOPLASMS OF UNSPECIFIED NATURE	D49.0

Childbirth

NORMAL DELIVERY	O80
OUTCOME OF DELIVERY	Z37.0

Heart Attack (Myocardial Infarction) OR Heart Disease

ACUTE MYOCARDIAL INFARCTION	I21.09
ANEURYSM OF HEART	I25.3
ANEURYSM OF CORONARY VESSELS	I25.41
DISSECTION OF CORONARY ARTERY	I25.42
OTHER ANEURYSM OF HEART	I25.3
RHEUMATIC FEVER WITHOUT MENTION HEART INVLV	I00
RHEUMATIC FEVER W/HEART INVOLVEMENT	I01.0
RHEUMATIC CHOREA	I02.0
CHRONIC RHEUMATIC PERICARDITIS	I09.2
DISEASES OF MITRAL VALVE	I05.0
DISEASES OF AORTIC VALVE	I06.0
DISEASES OF MITRAL&AORTIC VALVES	I08.0
DISEASES OF OTHER ENDOCARDIAL STRUCTURES	I07.0
OTHER RHEUMATIC HEART DISEASE	I09.0
ESSENTIAL HYPERTENSION	I10
HYPERTENSIVE HEART DISEASE	I11.9
HYPERTENSIVE HEART&RENAL DISEASE	I13.10
OTHER ACUTE & SUBACUTE FORMS ISCHEMIC HEART DISEASE	I24.8
OLD MYOCARDIAL INFARCTION	I25.2
ANGINA PECTORIS	I20.8
OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE	I25.10
ACUTE PULMONARY HEART DISEASE	I26.01
CHRONIC PULMONARY HEART DISEASE	I27.0
ACUTE PERICARDITIS	I32
ACUTE AND SUBACUTE ENDOCARDITIS	I33.0
ACUTE MYOCARDITIS	I41
OTHER DISEASES OF PERICARDIUM	I31.2
OTHER DISEASES OF ENDOCARDIUM	I34.0
CARDIOMYOPATHY	I42.3
CONDUCTION DISORDERS	I44.2
CARDIAC DYSRHYTHMIAS	I47.1

HEART FAILURE I50.20
ILL-DEFINED DESC&COMPLICATIONS HEART DISEASE I51.4

Stroke (Cerebrovascular Accident - CVA)
SUBARACHNOID HEMORRHAGE I60.00
INTRACEREBRAL HEMORRHAGE I61.0
OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE I62.1
OCCLUSION AND STENOSIS OF PRECEREBRAL ARTERIES I65.1
OCCLUSION OF CEREBRAL ARTERIES I66.01
TRANSIENT CEREBRAL ISCHEMIA G45.0
ACUTE BUT ILL-DEFINED CEREBROVASCULAR DISEASE I67.8
OTHER AND ILL-DEFINED CEREBROVASCULAR DISEASE I67.2
LATE EFFECTS OF CEREBROVASCULAR DISEASE I69.01

ESSENTIAL COVERAGE

What is the Essential Coverage?
The Coverage pays 100% of the charges a covered person incurs for covered preventive health services. There is a $50 co-pay per prescription for brand name contraceptive prescription drugs. There are no other co-pays, deductibles or maximums.

What does "covered preventive health services" mean?
Covered preventive health services are services that meet the requirements of the Affordable Care Act as determined by the federal government.

What does "co-pay" mean?
A co-pay is the specified amount that you are responsible for paying each time you incur charges for covered brand name contraceptive prescription drugs, before the Coverage begins to pay benefits.

What does "usual and customary" mean?
Usual and customary is a guideline that the carrier uses to determine how much of a charge the Coverage will consider. A "usual" charge is the charge made for a given service by a provider to the majority of its patients. A "customary" charge is one that is charged by the majority of providers within a community for the same services.

How do I file a claim to be reimbursed for payment of a covered expense?
Your provider will most likely want to file a claim for you using his or her own form; however, there are some instances when you may have to pay for services or supplies and submit a claim for reimbursement. For example, your doctor may place you on an aspirin regiment to prevent heart disease, but you must pay for the aspirin when you purchase it. In order to be reimbursed for that purchase, you may submit a claim for reimbursement.

You may request a claim form from your Employer, or you may call the RSL Specialty Products Administration at 1-866-375-0775. You can then fill out the claim form, include a copy of the receipt showing the name of the drug and the date the prescription was filled and mail it to: RSL Specialty Products Administration, Claims Department, 505 S. Lenola Road, Suite 231, Moorestown, NJ 08057. Claims must be submitted within one year of the date of the loss. For Claims Customer Service call 1-866-375-0775, Monday through Friday, 8:30 a.m. to 5:30 p.m., ET.

Can I use any pharmacy to get covered preventive prescription drugs?
Yes, but you can use the Prescription Drug ID Card received with the Coverage to help save money at a pharmacy that participates in the Express Scripts, Inc. network.

How does the Prescription Drug ID Card work?
Most pharmacies participate in the Express Scripts, Inc. network, but you should check with the pharmacy before you make your purchase or call Express Scripts, Inc. at 1-866-282-1491 for providers in your area. You will not have to file a claim on purchases you make for covered preventive prescriptions at participating pharmacies. The pharmacist will tell you exactly what to pay.

What if I use a non-participating pharmacy?
You must pay the full price up front for your covered preventive drug prescription. Then you must call Express Scripts, Inc. at 1-866-282-1491 and request a claim form. File the claim with Express Scripts, Inc. Do not file your prescription drug claims with RSL Specialty Products Administration.

EXCLUSIONS AND LIMITATIONS
No benefits will be paid for loss caused by or resulting from:
- injury or self-inflicted bodily harm;
- sickness or disease of any kind;
- acts of declared or undeclared war;
- the covered person's commission of a felony;
- charges in excess of the lesser of actual or usual and customary charges;
- preventive health services not meeting the requirements of the Affordable Care Act;
- dental care, treatment or supplies, except those specifically included as a covered preventive health service for a child;
- laboratory, radiology, or cardiovascular tests performed for the diagnosis or treatment of sickness, disease or injury; and
- preventive health services rendered by an immediate family member or provided by your employer.

COVERED PREVENTIVE HEALTH SERVICES
Listed below are most of the covered preventive health services. A service that is not listed may also be covered as long as it is a covered preventive health service.
Note: Many preventive health services have specific restrictions and/or limitations affecting the circumstances under which coverage will be provided.

For Adults
- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked;
- Alcohol Misuse screening and counseling;

- Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk;
- Blood Pressure screening for all adults;
- Cholesterol screening for adults of certain ages or at higher risk;
- Colorectal Cancer screening for adults over 50;
- Depression screening for adults;
- Diabetes (Type 2) screening for adults with high blood pressure;
- Diet counseling for adults at higher risk for chronic disease;
- HIV screening for everyone ages 15 to 65, and other ages at increased risk;
- HIV preexposure prophylaxis (PrEP) medication for people at increased risk of HIV acquisition;
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza (Flu Shot)
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
- Obesity screening and counseling for all adults;
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
- Statin preventive medication for adults 40 to 75 at high risk;
- Syphilis screening for all adults at higher risk;
- Tobacco Use screening for all adults and cessation interventions for tobacco users.

For Women

- Anemia screening on a routine basis for pregnant women;
- Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer;
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40;
- Breast Cancer Chemoprevention counseling for women at higher risk;
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women;
- Cervical Cancer screening;
- Pap test (also called a Pap smear) every 3 years for women 21 to 65;
- Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women 30 to 65 who don't want a Pap smear every 3 years;
- Chlamydia Infection screening for younger women and other women at higher risk;
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs);
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before;
- Domestic and interpersonal violence screening and counseling for all women;
- Folic Acid supplements for women who may become pregnant;
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
- Gonorrhea screening for all women at higher risk;
- Hepatitis B screening for pregnant women at their first prenatal visit;
- HIV screening and counseling for sexually active women;
- HIV preexposure prophylaxis (PrEP) medication for people at increased risk of HIV acquisition;
- Osteoporosis screening for women over age 60 depending on risk factors;
- Preeclampsia prevention and screening for pregnant women with high blood pressure;
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
- Sexually Transmitted Infections counseling for sexually active women;
- Syphilis screening for all pregnant women or other women at increased risk;
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users;
- Urinary tract or other infection screening for pregnant women;
- Urinary incontinence screening for women yearly;
- Well-woman visits to get recommended services for women under 65.

For Children

- Alcohol, tobacco, and drug use assessments for adolescents;
- Autism screening for children at 18 and 24 months;

- Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Bilirubin concentration screening for newborns;
- Blood Pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Blood screening for newborns;
- Cervical Dysplasia screening for sexually active females;
- Depression screening for adolescents;
- Developmental screening for children under age 3;
- Dyslipidemia screening for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Fluoride Chemoprevention supplements for children without fluoride in their water source;
- Fluoride varnish for all infants and children as soon as teeth are present;
- Gonorrhea preventive medication for the eyes of all newborns;
- Hearing screening for all newborns;
- Height, Weight and Body Mass Index measurements for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Hematocrit or Hemoglobin screening for children;
- Hemoglobinopathies or sickle cell screening for newborns;
- HIV screening for adolescents at higher risk;
- HIV preexposure prophylaxis (PrEP) medication for people at increased risk of HIV acquisition;
- Hypothyroidism screening for newborns;
- Immunization vaccines for children from birth to age 18 - doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Haemophilus influenzae Type B, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella (Chickenpox);
- Iron supplements for children ages 6 to 12 months at risk for anemia;
- Lead screening for children at risk of exposure;
- Medical History for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Obesity screening and counseling;
- Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years;
- Phenylketonuria (PKU) screening for this genetic disorder in newborns;
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
- Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Vision screening for all children.

DENTAL COVERAGE

What is the Dental Coverage?
The Dental Coverage pays a percentage of the charges a covered person incurs for covered dental procedures up to a per person maximum benefit of $1,000 each coverage year. There is a $50 per person deductible each coverage year. The Schedule of Covered Procedures and Benefits can be found at the end of the Dental Coverage section. Certain types of procedures are subject to waiting periods and frequency limitations.

What is a "deductible"?
A deductible is the amount of money you must pay for eligible expenses before the Dental Coverage begins to pay benefits.

What does "usual and customary" mean?
Usual and customary is a guideline that the carrier uses to determine how much of a dental expense the Dental Coverage will consider. A "usual" charge is the charge made for a given service by a provider to the majority of its patients. A "customary" charge is one that is charged by the majority of providers within a community for the same services.

What is a "waiting period"?
A waiting period is the amount of time which coverage must be in force before benefits may become payable for covered procedures.

EXCLUSIONS AND LIMITATIONS
No benefits will be paid for loss caused by or resulting from:

- Service or supply not shown on the list of covered procedures;
- Any procedure begun after your Dental Coverage ends, or for any prosthetic dental appliance finally installed or delivered more than 30 days after your Dental Coverage ends;
- Any procedure begun or appliance installed before your Dental Coverage began;
- Any treatment that is elective or primarily cosmetic in nature and not generally recognized as an accepted dental practice by the American Dental Association;
- The correction of congenital malformations (unless the procedure is performed on a covered person who was covered immediately following birth);
- The replacement of lost or stolen appliances;
- Initial placement of any prosthetic appliance or fixed bridge unless such placement is necessitated by the extraction of one or more functioning natural teeth while insured, provided such tooth was not an abutment for a prosthetic appliance installed during the preceding 5 years or a fixed bridge installed during the preceding 7 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth;
- Replacement of bridges unless the bridge cannot be made serviceable;
- Replacement of full or partial dentures unless the prosthetic appliance is more than 5 years old and cannot be made serviceable;
- Replacement of crowns, inlays, or onlays unless the prior placement is more than 7 years old and cannot be made serviceable;
- Appliances, services, or procedures relating to the change or maintenance of vertical dimension, restoration of occlusion, splinting, correction of attrition or abrasion, bite registration, or bite analysis;
- Services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, or myofascial pain;
- Orthognathic surgery;
- Prescribed drugs, pre-medication, analgesia, or general anesthesia;
- Any instruction for diet, plaque control, and oral hygiene;
- Dental disease, defect, or injury caused by a declared or undeclared war or any act of war;
- Implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, over-dentures and any associated surgery, or other customized services or attachments;
- Cast restorations and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means;
- Treatment of malignancies, cysts, and neoplasms;
- Orthodontic treatment;
- Failure to keep a scheduled visit or charges for the completion of any claim forms;
- Any procedure, determined by the carrier, that is not necessary, does not offer a favorable prognosis, does not have uniform professional endorsement, or that is experimental in nature;
- Service or supply rendered by someone who is related to a covered person by blood (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law), or adoption or is normally a member of the covered person's household;
- Any procedure, service, or supplies that are included as covered medical expenses under a group medical expense benefit plan;

- Expenses compensable under Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law (including, but not limited to, group, group-type, and individual automobile "no-fault" coverage);
- Expenses provided or paid for by any governmental program or law, except as to charges that the person is legally obligated to pay; and
- Charges in excess of usual and customary fee levels, based on the 90th percentile of the FAIR Health, Inc. MDR tables.

The procedures listed above will also not be recognized toward satisfaction of any deductible amount.

SCHEDULE OF COVERED PROCEDURES AND BENEFITS

Covered persons are covered only for the procedures and benefits shown below. All benefits are expressed as a percentage of the lesser of actual or usual and customary charges. Note: Limitations (a) through (h) are explained at the end of the Schedule.

COVERAGE A - No Waiting Period

D0150	Comprehensive oral exam (a)	80%
D0120	Periodic oral exam (a)	80%
D0140	Limited oral evaluation - problem focused	80%
D9110	Palliative (emergency) treatment of dental pain – minor procedure	80%
D0330	Panoramic film (b), or	80%
D0210	Intraoral - complete series (b)	80%
D0220	Intraoral - perapical, first film	80%
D0230	Intraoral - perapical, each additional film	80%
D0240	Intraoral - occlusal film	80%
D0270	Bitewing - single film (f)	80%
D0272	Bitewing - two films (f)	80%
D0274	Bitewing - four films (f)	80%
D1110	Prophylaxis - adult (a)	80%
D1120	Prophylaxis - child (a)(e), or	80%
D1203	Topical application of fluoride – child (no prophylaxis) (a)(e)	80%
D1351	Sealant - per tooth (c)(e)	80%
D1510	Space maintainer - fixed-unilateral (c)(e)	80%
D1515	Space maintainer - fixed bilateral (c)(e)	80%
D1520	Space maintainer - removable – unilateral (c)(e)	80%
D1525	Space maintainer - removable – bilateral (c)(e)	80%

COVERAGE B – Three Month Waiting Period

Fillings

D2140	Amalgam - one surface, Primary or Permanent	60%
D2150	Amalgam - two surfaces, Primary or Permanent	60%
D2160	Amalgam - three surfaces, Primary or Permanent	60%
D2161	Amalgam - four+ surfaces, Primary or Permanent	60%
D2330	Resin-based composite - one surface, anterior	60%
D2331	Resin-based composite - two surfaces, anterior	60%
D2332	Resin-based composite - three surfaces, anterior	60%
D2335	Resin-based composite - four+ surfaces or involving incisal angle (anterior)	60%
D2391	Resin-based composite - one surface, posterior – Primary or Permanent	60%
D2392	Resin-based composite - two surfaces, posterior – Primary or Permanent	60%
D2393	Resin-based composite - three surfaces, posterior – Primary or Permanent	60%
D2394	Resin-based composite – four+ surfaces, posterior – Primary or Permanent	60%
D2940	Sedative filling	60%

Oral Surgery

D7140	Simple Extraction – Erupted Tooth or Exposed Root	60%
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	60%
D7220	Removal of impacted tooth - soft tissue	60%
D7230	Removal of impacted tooth - partially bony	60%
D7240	Removal of impacted tooth - completely bony	60%
D7250	Surgical removal of residual tooth roots (cutting procedure)	60%
D7310	Alveoloplasty in conjunction with extractions - per quadrant	60%
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	60%
D7510	Incision and drainage of abscess - intraoral soft tissue	60%

Crown & Bridge Repair

D2910	Recement inlay	60%
D2920	Recement crown	60%
D2950	Core buildup, including any pins	60%
D2951	Pin retention - per tooth, in addition to restoration	60%

D6930 Recement fixed partial denture 60%

Denture Repair

D5510 Repair broken complete denture base (c) 60%
D5520 Replace missing or broken teeth - complete denture (each tooth) (c) 60%
D5610 Repair partial resin denture base (c) 60%
D5620 Repair partial cast framework (c) 60%
D5630 Repair or replace broken clasp (c) 60%
D5640 Replace broken teeth - per tooth (c) 60%
D5650 Add tooth to existing partial denture (c) 60%
D5660 Add clasp to existing partial denture (c) 60%
D5730 Reline complete maxillary denture (chairside) (b) 60%
D5731 Reline complete mandibular denture (chairside) (b) 60%
D5740 Reline maxillary partial denture (chairside) (b) 60%
D5741 Reline mandibular partial denture (chairside) (b) 60%
D5750 Reline complete maxillary denture (lab) (b) 60%
D5751 Reline complete mandibular denture (lab) (b) 60%
D5760 Reline maxillary partial denture (lab) (b) 60%
D5761 Reline mandibular partial denture (lab) (b) 60%

Endodontics

D3110 Pulp cap - direct (excluding final restoration) 60%
D3120 Pulp cap - indirect (excluding final restoration) 60%
D3220 Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament 60%
D3310 Root canal - anterior (excluding final restoration) (c), or 60%
D3320 Root canal - bicuspid (excluding final restoration) (c), or 60%
D3330 Root canal - molar (excluding final restoration) (c) 60%
D3410 Apicoectomy/periradicular surgery - anterior (c), or 60%
D3421 Apicoectomy/periradicular surgery - bicuspid (first root) (c), or 60%
D3425 Apicoectomy/periradicular surgery - molar (first root) (c) 60%
D3426 Apicoectomy/periradicular surgery - (each additional root) 60%
D3430 Retrograde filling - per root 60%
D3460 Root amputation - per root 60%

COVERAGE C - Twelve Month Waiting Period

Periodontics

D4210 Gingivectomy or gingivoplasty - per quadrant (g) 50%
D4211 Gingivectomy or gingivoplasty - per tooth 50%
D4260 Osseous surgery (including flap entry and closure) – per quadrant (h), or 50%
D4341 Periodontal scaling & root planing - per quadrant (h) 50%
D4355 Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis (b) 50%
D4910 Periodontal maintenance procedures (following active therapy) (a) 50%

Crowns & Bridges

D2720 Crown - resin w/ high noble metal (d) 50%
D2721 Crown - resin w/ predominantly base metal (d) 50%
D2722 Crown - resin with noble metal (d) 50%
D2740 Crown - porcelain/ceramic substrate (d) 50%
D2750 Crown - porcelain fused to high noble metal (d) 50%
D2751 Crown - porcelain fused to predominantly base metal (d) 50%
D2752 Crown - porcelain fused to noble metal (d) 50%
D2790 Crown - full cast high noble metal (d) 50%
D2791 Crown - full cast predominantly base metal (d) 50%
D2792 Crown - full cast noble metal (d) 50%
D2780 Crown - 3/4 cast high noble metal (d) 50%
D2930 Prefabricated stainless steel crown - primary tooth (d) 50%
D2932 Prefabricated resin crown (d) 50%
D2952 Cast post and core in addition to crown (d) 50%
D2954 Prefabricated post and core in addition to crown (d) 50%
D6210 Pontic - cast high noble metal (d) 50%
D6211 Pontic - cast predominantly base metal (d) 50%
D6212 Pontic - cast noble metal (d) 50%
D6240 Pontic - porcelain fused to high noble metal (d) 50%
D6241 Pontic - porcelain fused to predominantly base metal (d) 50%
D6242 Pontic - porcelain fused to noble metal (d) 50%
D6245 Pontic - porcelain/ceramic (d) 50%
D6250 Pontic - resin with high noble metal (d) 50%
D6251 Pontic - resin with predominantly base metal (d) 50%
D6252 Pontic - resin with noble metal (d) 50%

D6720 Crown - retainer - resin with high noble metal (d) 50%
D6721 Crown - retainer - resin with predominantly base metal (d) 50%
D6722 Crown - retainer - resin with noble metal (d) 50%
D6740 Crown - porcelain/ceramic (d) 50%
D6750 Crown - retainer - porcelain fused to high noble metal (d) 50%
D6751 Crown - retainer - porcelain fused to predominantly base metal (d) 50%
D6752 Crown - retainer - porcelain fused to noble metal (d) 50%
D6780 Crown - retainer - 3/4 cast high noble metal (d) 50%
D6790 Crown - retainer - full cast high noble metal (d) 50%
D6791 Crown - retainer - full cast predominantly base metal (d) 50%
D6792 Crown - retainer - full cast noble metal (d) 50%
D6970 Cast post and core in addition to fixed partial denture retainer (d) 50%
D6972 Prefabricated post and core in addition to fixed partial denture retainer (d) 50%
D6973 Core build up for retainer, including any pins (d) 50%

Dentures

D5110 Complete denture - maxillary (d) 50%
D5120 Complete denture - mandibular (d) 50%
D5130 Immediate denture - maxillary (d) 50%
D5140 Immediate denture - mandibular (d) 50%
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth) (d) 50%
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth) (d) 50%
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth) (d) 50%
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth) (d) 50%
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth) (d) 50%
D5410 Adjust complete denture - maxillary (d) 50%
D5411 Adjust complete denture - mandibular (d) 50%
D5421 Adjust partial denture - maxillary (d) 50%
D5422 Adjust partial denture - mandibular (d) 50%
D5710 Rebase complete maxillary denture (d) 50%
D5711 Rebase complete mandibular denture (d) 50%
D5720 Rebase maxillary partial denture (d) 50%
D5721 Rebase mandibular partial denture (d) 50%
D5850 Tissue conditioning - maxillary (d) 50%
D5851 Tissue conditioning – mandibular (d) 50%

Limitations:

(a) Maximum of 1 procedure per 6 months
(b) Maximum of 1 procedure per 36 months
(c) Maximum of 1 procedure per 12 months
(d) Maximum of 4 procedures of this class per 12 months
(e) Limited to dependent children under 14
(f) Maximum of 4 films per 12 months
(g) Maximum of once each quadrant per 36 months
(h) Maximum of once each quadrant per 6 months

TERM LIFE COVERAGE

What is the life insurance benefit?
If you, the employee, die while you are covered by the life insurance benefit, your beneficiary will be paid $10,000. If your death is as the result of a covered accident, your beneficiary will be paid an additional $10,000. If any of your dependents older than 6 months, which you have enrolled in Dependent Term Life Coverage, die while covered, you will be paid $2,500. There is no matching accidental death benefit available for covered dependents. The benefit for dependents age 6 months or less is $500. Employee benefits under this coverage are reduced by 50% at age 70 and spouse benefits end when they reach age 70.

Who is the life insurance beneficiary?
Your life insurance benefits will be paid in equal shares to members of the first surviving class, as follows: spouse; children; parents; and then brothers and sisters. If no class has a survivor, the beneficiary is your estate. If you have selected coverage for your dependents, you are automatically the beneficiary for their life insurance benefits. If you are not living on the date of a covered dependent's death, the beneficiary is your estate.

CONVERSION OF YOUR TERM LIFE COVERAGE

What if I'm no longer employed, can I keep my Term Life Coverage?
Yes. If you had Term Life Coverage and now you are no longer employed or are not eligible, you have the right to convert your Term Life Coverage (not including the matching accidental death benefit) to an Individual Ordinary Life Policy. This must be done within 31 days of the end of your coverage.

How much will the conversion policy cost?
It will usually cost a lot more than what you previously paid for your Employer's Program. The cost will be based on your age and other factors.

What if I do want to convert my Term Life Coverage?
If you would like to apply for the conversion policy, you should contact the ERISA Plan Administrator for assistance with the application process.

EXCLUSIONS AND LIMITATIONS
The life insurance benefit is not payable for any loss of life during the first two years of coverage if death is caused by or results from suicide, while sane or insane.

The accidental death benefit is not payable for loss caused by or resulting from:

- Attempted suicide or intentionally self-inflicted injury, while sane or insane;
- Voluntarily taking poison, inhaling gas, or taking a drug or chemical not administered by a physician;
- War or any act of war, whether declared or not;
- Your commission of, or attempt to commit, a felony, or any loss sustained while incarcerated for the felony;
- Your participation in a riot;
- Your engaging in an illegal occupation;
- Release of nuclear energy;
- Your operating, riding in, or descending from any aircraft (including a hang glider), other than while a passenger on a licensed, commercial, non-military aircraft; and
- Bodily or mental infirmity, disease of any kind, or medical or surgical treatment for that infirmity or disease. This does not include bacterial infections resulting from an accidental cut or wound, or accidental ingestion of a poisonous food substance.

SHORT-TERM DISABILITY COVERAGE

What is the benefit for Short-Term Disability (STD)?
The STD Coverage pays up to 50% of your average weekly base pay received for work done for the ERISA Plan Sponsor (plus reported tips, but no overtime), subject to a maximum of $125 a week. For example, if you normally make $200 a week at your job, you will be paid $100 per week in STD payments. The STD Coverage pays for a maximum of 26 weeks. Your benefits under this coverage are reduced by 50% at age 70. In addition, while receiving benefits under this coverage, you do not have to pay the STD premiums. Enrollment in this coverage is only available to you, the employee. It is not available to your dependents.

When would I start receiving STD payments?
They begin after a 14-day elimination period; however, if you are hospitalized during that 14-day period, the STD Coverage begins paying immediately. To receive the benefits, you must become totally disabled due to a sickness while you are covered under the STD Coverage, or due to an injury from an accident that happens while you are covered under the STD Coverage. Total disability due to an injury must occur within 90 days of the accident.

What does "totally disabled" mean?
If you cannot do the duties generally and regularly required by your type of work due to injury or sickness, and your disability requires treatment by a licensed physician, you will be considered totally disabled. If you are no longer totally disabled, your benefits will cease. If you have several periods of total disability due to the same or related causes, and they are separated by less than 2 straight weeks of work (at your regular schedule), the STD Coverage will treat this as one period.

EXCLUSIONS AND LIMITATIONS
No benefits will be paid for a disability caused by or resulting from:

- Work-related injury or sickness, whether or not benefits are payable under Workers' Compensation or similar law;
- Attempted suicide or intentionally self-inflicted injury, while sane or insane;
- Voluntarily taking poison, inhaling gas, or taking a drug or chemical not administered by a physician;
- War or any act of war, whether declared or not;
- Your commission of, or attempt to commit, a felony, or any loss sustained while incarcerated for the felony;
- Your participation in a riot;
- Your engaging in an illegal occupation;
- Release of nuclear energy; and
- Your operating, riding in, or descending from any aircraft (including a hang glider), other than while a passenger on a licensed, commercial, non-military aircraft.

AVAILABILITY
If you work in California, Hawaii, New Jersey, New York, Rhode Island, or Puerto Rico, STD coverage is not available.

FILING A CLAIM

How do I file a claim under the BasicAdvantage Total, Essential or Dental Coverage?
Your provider will most likely want to file a claim for you using his or her own form. If you need to file a claim yourself, you may request a claim form from your Employer, or you may call the RSL Specialty Products Administration at 1-866-375-0775 or by visiting www.helpwithmyplan.com. Claims should be mailed to: RSL Specialty Products Administration, Claims Department, 505 S. Lenola Road, Suite 231, Moorestown, NJ 08057. Claims must be submitted within one year of the date of the loss. Under the BasicAdvantage Total Coverage, the carrier reserves the right to require a medical examination at its expense. For Claims Customer Service call 1-866-375-0775, Monday through Friday, 8:30 a.m. to 5:30 p.m., ET.

When will I know if my BasicAdvantage Total, Essential or Dental Coverage claim is denied?
If all or a part of your claim is denied, you will be notified in writing within 30 days from the date your claim was received. Under some circumstances, the carrier can notify you that it is extending this 30-day time frame by an additional 15 days. The denial notice will include: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a description of any information needed to make the claim complete; (d) a statement of your right to review (on request and at no charge) relevant internal guidelines, documents, and other information; and (e) an explanation of how to appeal for reconsideration of the decision, including your right to bring a lawsuit. If you are required to submit additional information to support your claim, you will have 45 days to do so.

How do I appeal a denied claim under the BasicAdvantage Total, Essential or Dental Coverage?
If you disagree with the decision, you may request a review within 180 days of the initial denial. If you do not submit your appeal on time, you generally will lose the right to appeal the denial. Your appeal must be in writing, clearly stating the reason you believe the denial is incorrect, and include any additional documentation that you feel would support a further review of your claim. You (on request and at no charge) may have reasonable access to and receive copies of all relevant documents concerning your claim. The reviewer of your appeal will be a different person or persons from the reviewer of your initial claim and will not be a subordinate of the initial reviewer. Your claim will be reviewed and a decision will be issued within 60 days from the date your appeal was received. If the decision on appeal continues to deny your claim, you will be furnished with a notice of adverse benefit determination on review, setting forth: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a statement of your right to review (on request and at no charge) relevant internal guidelines, documents, and other information; and (d) a statement of your right to bring a lawsuit.

Is there any coordination of benefits under the BasicAdvantage Total or Essential Coverage?
Neither the BasicAdvantage Total Coverage nor the Essential Coverage coordinate its benefits with any other coverage you might have. That means your benefits will not be reduced because you have other coverage that pays you for the same expenses. If you have coverage from another source, that other coverage could reduce their benefits based on what the BasicAdvantage Total or Essential Coverage pays. An example would be the Medicare or Medicaid programs. Their rules require that your benefits under those programs be reduced by the amount of benefits you would receive under the BasicAdvantage Total or Essential Coverage.

How do I (or how does my beneficiary) file a Term Life claim?
If a covered person dies as the result of an accident or illness, you or your beneficiary should apply for the insurance benefit as soon as possible. You or your beneficiary can obtain the appropriate forms and details about the claims procedure by calling RSL Specialty Products Customer Service at 1-866-375-0775, Monday through Friday, 8:30 a.m. to 5:30 p.m., ET.

When will I (or my beneficiary) know if the Term Life claim is denied?
If all or a part of the claim is denied, you or your beneficiary will be notified in writing within 90 days from the date the claim was received. Under some circumstances, the carrier can notify you or your beneficiary that it is extending this 90-day time frame by an additional 90 days. The denial notice will include: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a description of any information needed to make the claim complete; (d) a statement of your or your beneficiary's right to review (on request and at no charge) relevant internal guidelines, documents and other information; and (e) an explanation of how to appeal for reconsideration of the decision.

How do I (or how does my beneficiary) appeal a denied Term Life claim?
If you or your beneficiary disagree with the decision, a review may be requested within 60 days of the initial denial. If the appeal is not submitted on time, you or your beneficiary generally will lose the right to appeal the denial. The appeal must be in writing, clearly stating the reason you or your beneficiary believes the denial is incorrect, and include any additional documentation that would support a further review of the claim. You or your beneficiary (on request and at no charge) may have reasonable access to and receive copies of all relevant documents concerning the claim. The claim will be reviewed and a decision will be issued within 60 days from the date the appeal was received. Under some circumstances, the carrier can notify you or your beneficiary that it is extending this 60-day time frame by an additional 60 days. If the decision on appeal continues to deny the claim, you or your beneficiary

will be furnished with a notice of adverse benefit determination on review, setting forth: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a statement of your or your beneficiary's right to review (on request and at no charge) relevant internal guidelines, documents and other information; and (d) a statement of your or your beneficiary's right to bring a lawsuit.

How do I file an STD claim?
If you become totally disabled while covered under the STD Coverage you should apply for the insurance benefit as soon as possible. You may request a claim form from your Employer or you may call RSL Specialty Products Customer Service at 1-866-375-0775 or by visiting www.helpwithmyplan.com. Be sure to have your Employer complete their part of the claim form and have your doctor complete their part of the claim form including the dates of disability. Claims should be mailed to: RSL Specialty Products Administration, Claims Department, 505 S. Lenola Road, Suite 231, Moorestown, NJ 08057. Claims must be submitted within one year of the date of the loss. The carrier reserves the right to require a medical examination at its expense. For Claims Customer Service, call 1-866-375-0775, Monday through Friday, 8:30 a.m. to 5:30 p.m., ET.

When will I know if my STD claim is denied?
If all or a part of your claim is denied, you will be notified in writing within 45 days from the date your claim was received. Under some circumstances, the carrier can notify you that it is extending this 45-day time frame by an additional 30 days. The denial notice will include: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a description of any information needed to make the claim complete; (d) a statement of your right to review (on request and at no charge) relevant internal guidelines, documents, and other information; and (e) an explanation of how to appeal for reconsideration of the decision. If you are required to submit additional information to support your claim, you will have 45 days to do so.

How do I appeal a denied STD claim?
If you disagree with the decision, you may request a review within 180 days of the initial denial. If you do not submit your appeal on time, you generally will lose the right to appeal the denial. Your appeal must be in writing, clearly stating the reason you believe the denial is incorrect, and include any additional documentation that you feel would support a further review of your claim. You (on request and at no charge) may have reasonable access to and receive copies of all relevant documents concerning your claim. The reviewer of your appeal will be a different person or persons from the reviewer of your initial claim and will not be a subordinate of the initial reviewer. Your claim will be reviewed and a decision will be issued within 45 days from the date your appeal was received. Under some circumstances, the carrier can notify you that it is extending this 45-day time frame by an additional 45 days. If the decision on appeal continues to deny your claim, you will be furnished with a notice of adverse benefit determination on review, setting forth: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a statement of your right to review (on request and at no charge) relevant internal guidelines, documents, and other information; and (d) a statement of your right to bring a lawsuit.

What if I (or my beneficiary) miss a deadline for filing or appealing any claim?
If you or your beneficiary do not submit a claim on time, do not appeal on time, or do not otherwise follow the claims procedures, you or your beneficiary may lose the right to file suit in court because of failure to exhaust the internal administrative appeals rights, which may be a prerequisite to bringing suit.

HIPAA NOTICE

Reliance Standard Life Insurance Company
First Reliance Standard Life Insurance Company
Reliance Standard Life Insurance Company of Texas

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice applies to the BasicCare Program within Reliance Standard Life Insurance Company, First Reliance Life Insurance Company, and Reliance Standard Life Insurance Company of Texas (collectively "Reliance Standard"). We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us.

Reliance Standard Office Contact Information: To assert any of your rights with respect to this Notice, or to obtain an authorization form, please call 1-800-487-5553 and request the appropriate form. Please direct any questions about this Notice or requests for further information, or to file a complaint: The Privacy Office, Attn. HIPAA Privacy, 1700 Market Street, Suite 1200, Philadelphia, PA 19103-3938

YOUR RIGHTS

You have the right to:

Get a copy of your claims records
- You can ask to see or get a copy of your claims records we maintain about you. Ask us how to do this.
- We will provide a copy or a summary of your claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Correct your claims records
- You can ask us to correct your claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

Request confidential communication
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit the information we share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect payment for your care.

Get a list of those with whom we've shared your information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
- We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Privacy Notice
You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you believe your privacy rights have been violated
- You can complain if you feel we have violated your rights by contacting us using the contact information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/ privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
- **Answer coverage questions from your family and friends**
  At your directions we will share information with your family, close friends, or others involved in payment for your care.
- **Share information in a disaster relief situation.**

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will not share your personal information for marketing purposes or sell your personal information unless you give us your written permission to do so.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

Example: We use health information about you to develop better coverage and service offerings for our insured members, including you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with other health benefit plans that you might also be covered by to coordinate payment for your health services.

Administer your health plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/ consumers/index.html.

Help with public health and safety issues – We can share your health information in certain situations such as to help prevent disease or to report suspected abuse, neglect or domestic violence.

Comply with the law – We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests – We can share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.

Respond to lawsuits and legal actions – We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
This Revised Notice is effective 9/23/13.

ID CARDS

Please Remember:

- ID Cards are only valid if 1) you have enrolled AND 2) your first premium has been paid.
- If you have elected BasicAdvantage Total Coverage and/or Essential Coverage, the ID Card will include information your pharmacist will use when you have a prescription filled. ID Cards are mailed to your home; however, they may also downloaded from www.helpwithmyplan.com once you register to use the site.
- The Dental ID Card is included below. If you have elected Dental Coverage, cut out the Dental ID Card and print and sign your name.
- Carry your ID Card(s) with you when you visit a health care provider. Information on the card(s) will help the provider to file a claim for you.
- ID Cards are not proof of coverage under any plan.
- ID Cards become void if your coverage is terminated.

IF YOU HAVE ENROLLED FOR BASICADVANTAGE TOTAL COVERAGE, CUT OUT THE VSP ACCESS PLAN MEMBERSHIP CARD AND KEEP IN YOUR WALLET.

IF YOU HAVE ENROLLED FOR DENTAL COVERAGE, CUT OUT THE DENTAL ID CARD, PRINT AND SIGN YOUR NAME, AND KEEP IN YOUR WALLET.

RELIANCE STANDARD
LIFE INSURANCE COMPANY

PERMANENT DENTAL IDENTIFICATION CARD

Company Name: **University of Illinois**

Group Number: **BCD003260**

Print Name:

Signature:

THIS PLAN DOES NOT REQUIRE PREDETERMINATION OF BENEFITS

VSP *Access* PLAN

VSP

As a VSP member, you'll receive the following Access Plan discounts from a VSP network doctor:

- 20% discount on your eye exam
- 20% discount on your frame, lenses and lens options when a complete pair of prescription glasses is purchased
- 15% discount on your contact lens exam (fitting & evaluation)
- Discounts on laser vision correction

These discounts are only available from the VSP network doctor who provided your eye exam within the past 12 months.

Questions? Visit our Web site at vsp.com or Call VSP at 800-877-7195

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RSL Specialty Products Customer Service: 1-866-375-0775

Payer ID: ASRM1
For information on electronic claims submission, visit:
http://www.claimsnet.com/asrm

Dental Care Provider: The person who signed this card has been enrolled under a Group Limited Dental Benefits Plan sponsored by the employer shown on the front of this card. The dental benefits do not have a network requirement or co-pay. This card is for identification only. It is not a guarantee of eligibility for benefits. All decisions on eligibility, coverage, and payment of benefits are the responsibility of Reliance Standard Life Insurance Company.

Mail Dental Claims to: RSL Specialty Products Administration
Claims Department
505 South Lenola Road, Suite 231
Moorestown, NJ 08057