

Expanding choices.



Partners In Community Supports BasicMed Program

Employee Brochure



Important protection for **You** and **Your** dependents ...
made available by your employer ... through easy payroll deduction.

Your acceptance is **Guaranteed** — you cannot be turned down,
as long as you sign-up during your open enrollment period.

Medical

This is not a comprehensive major medical plan, nor is it intended to replace a major medical plan. The plan is intended to provide you, and your covered dependents, with basic insurance coverage.

- Visit any doctor or hospital.
- Enrolled dependents receive the same coverage as you.
- No pre-existing conditions exclusions or limitations.
- Medical Plan enrollees also receive these added benefits:
 - Prescription Drug Card offering discounts at participating pharmacies.
 - VSP Access Plan membership offering discounts on eye exams and prescription glasses at network doctors.

Inpatient Hospital Benefits – Treatment for Sickness	
Maximum Benefit per coverage year	\$7,500
Subject to these benefit limits:	
Room & Board per day	\$400
Surgeons' Fees per coverage year	\$1,000
Anesthesiologists' Fees per coverage year	\$200
Benefit % paid by plan	70%
Inpatient Hospital Benefits – Treatment for Accident	
Maximum Benefit per coverage year	\$5,000
Benefit % paid by plan	70%
Outpatient Benefits	
Maximum Benefit per coverage year	\$750
Benefit % paid by plan (except for Doctor Office Visits)	70%
Doctor Office Visits Co-pay per visit	\$20
Benefit % paid by plan for Doctor Office Visits	100%
Emergency Room Benefits	
Treatment for Sickness - Maximum Benefit per visit (limited to three visits per coverage year)	\$50
Treatment for Accident - Maximum Benefit per visit (limited to two visits per coverage year)	\$500
Benefit % paid by plan	100%
Wellness Care Visits Benefits	
Maximum Benefit per coverage year	\$100
Co-pay per visit	\$20
Benefit % paid by plan	100%
Prescription Drug Card Benefits	
Generic Drug Maximum Benefit per coverage year	\$750
Generic Drug Co-pay per prescription	\$5
Generic Drug Benefit % paid by plan	100%

- Where the benefit is expressed as a percentage, the basis of payment will be either the lower of actual or usual & customary charges or, when applicable, the negotiated network charges.
- After the \$20 co-pay for a doctor's office visit, the plan pays 100% of the remaining charge subject to the Outpatient Maximum Benefit. (Does not include tests, lab fees, x-rays, injections, etc., which are covered under the Outpatient Benefits.)

Dental

- Plan pays up to \$1,500 maximum per person each coverage year after a \$50 per person deductible.
- Visit any dentist.
- Covers most common services and gives your enrolled dependents the same coverage.

Types of Charges Covered by the Plan	Percent of Charges the Plan Pays	Waiting Period of Continuous Enrollment Before Plan Pays
Checkups & Routine Cleaning	80%	None
Bitewing X-Rays	80%	None
Sealants (for children)	80%	None
Fluoride Treatments (for children)	80%	None
Space Maintainers (for children)	80%	None
Fillings	70%	3 Months
Crown & Bridge Repair	70%	3 Months
Denture Repair	70%	3 Months
Oral Surgery	70%	3 Months
Endodontics (root canal & pulpal therapy)	70%	3 Months
Periodontics (treatment of gums)	60%	12 Months
Crowns & Bridges	60%	12 Months
Dentures	60%	12 Months

Questions & Answers

Who can be covered? In addition to covering yourself, dependent coverage is offered in the medical and dental plans. Your eligible dependents are your lawful spouse and your unmarried children through age 18 who live with you and depend on you for support (through age 24 if a full-time student), or through any age if handicapped and unable to earn a living.

When does my coverage begin and end? Your coverage begins on the first day of the pay period following the pay period in which a premium deduction occurs. Coverage for all of your benefits under the program will end if (1) the required premiums are not paid; (2) you are no longer an eligible employee; (3) the insurance policies terminate; or (4) you enter an Armed Service on full-time active duty.

When does dependent coverage begin and end? Your dependents' coverage begins when yours does, unless you enroll them later. If you do, their coverage will become effective after the written enrollment is approved and the premiums have been paid. Their coverage ends when yours does or when the dependent is no longer eligible.

What happens if I miss a premium payment? For any given pay period, if you haven't earned enough to have your premium deducted from your pay, you can ensure your continued coverage by sending the full premium directly to RSL Specialty Products Administration. If you missed more than one pay period in a row, you must make up all missed, consecutive premium deductions. If you do not, claims will not be paid for losses or expenses that occur during an unpaid period. Premiums due must be mailed within 45 days after the date of the missed deduction. If a missed premium is overdue by more than 45 days, it cannot be made up. The Summary Plan Description that you get after you enroll includes a Missed Premium Payment Form, which you can copy and use as needed.

Do I have to use certain doctors, dentists or hospitals? No. You are free to use any licensed doctor or dentist, or any certified hospital. However, under the medical plan, you can save money by using a network provider.

What is a co-pay? A co-pay is the amount that you are responsible for paying each time you incur covered expenses for doctors' office visits, wellness care visits, and prescription drugs.

What is "wellness care"? It is medical examinations and procedures that are preventative in nature and not for the treatment of an injury or sickness.

When will I receive ID cards and full coverage information? You will receive a Summary Plan Description after you enroll. ID cards will be included.

Does the medical plan cover maternity? Yes. Maternity is a covered expense.

Is chiropractic care covered under the medical plan? Yes.

Does the medical plan cover reconstructive surgery following a mastectomy? Yes. A covered person who has a mastectomy is covered by the medical plan for reconstruction of the affected breast, surgery and reconstruction of the other breast for appearance, and for prostheses and any physical complications at all stages of mastectomy (including lymphedemas) as determined by the attending doctor and patient. These services are subject to the same maximums and limits that would apply with respect to eligible expenses for any other covered loss.

Exclusions and Limitations

The following is just a summary. Please see your Summary Plan Description (SPD) for a more complete description of these items.

What is not covered under the Medical Plan...

- suicide or attempted suicide, or any intentionally self-inflicted injuries, while sane or insane;
- acts of war (declared or undeclared);
- the covered person's commission of a felony;
- services by an immediate family member or by your employer;
- mental or nervous disorders;
- alcoholism or substance abuse;
- sickness and injury related to the covered person's work;
- eye or hearing examinations, eye glasses or hearing aids;
- treatment in a government facility or other facility not unconditionally requiring payment;
- dental treatment or cosmetic surgery (except reconstructive breast surgery following a mastectomy);
- brand name drugs and drugs not requiring a prescription;
- expenses used towards co-pays, or in excess of benefit limits or maximums, or negotiated or usual & customary charges; and
- inpatient doctors' visits and inpatient private-duty nursing charges.

What is not covered under the Dental Plan ...

- procedures begun or appliances installed before coverage begins;
- elective or cosmetic treatment;
- correction of congenital malformations;
- replacement of lost or stolen appliances;
- initial placement of prosthesis or fixed bridge;
- replacement of serviceable bridges;
- replacement of serviceable dentures less than 5 years old;
- replacement of crowns, inlays, and onlays less than 7 years old;
- procedures involving vertical dimension, correction of attrition or abrasion, occlusion, splinting or bite analysis;
- services in any way related to TMJ or myofascial pain;
- orthognathic surgery;
- prescribed drugs, analgesic or anesthetics;
- instruction for diet, plaque control, and oral hygiene;
- acts of war (declared or undeclared);
- charges for implants or their removal and other customized services or attachments;
- cast restorations and crowns for healthy teeth that can be restored by other means;
- treatment of malignancies, cysts, and neoplasms;
- orthodontic treatment;

- charges for forms or missed appointments;
- treatment that is unnecessary, experimental, or does not offer a favorable prognosis;
- services rendered by an immediate family member;
- charges in excess of usual and customary fee levels based on the 90th percentile of the Ingenix MDR tables;
- expenses covered under a group medical expense plan;
- expenses payable under Workers' Compensation or other coverage required by law;
- expenses which the covered person is not legally obligated to pay; and
- any procedure begun after coverage ends or any prosthetic dental appliance finally installed more than 30 days after coverage ends.

Many covered procedures have continuous enrollment waiting periods and limitations on how often the plan will pay for them within a certain time frame. The plan will pay only for the procedures specified on the Schedule of Covered Procedures and Benefits in the SPD.

The Medical Plan and Dental Plan are underwritten by Reliance Standard Life Insurance Company, Philadelphia, Pennsylvania under group policy form series LRS-9167-1103, et al, and LRS-9171-1103, et al, respectively. VSP Access Plan discounts from Vision Service Plan.

Refer to the accompanying materials for information on payroll deductions.

Every effort has been made to ensure the accuracy of this enrollment brochure. The information described applies to the residents of most states, however state laws do vary. The laws of your state may affect this benefit program, but these differences generally do not reduce your benefits. This brochure is not a legal document. The contractual terms and conditions of coverage are set forth in the group policies. In the event of a discrepancy, the policies would be the determining factor. Insurance products and services are provided through Reliance Standard Life Insurance Company, which is licensed in all states (except New York), the District of Columbia, Puerto Rico, & the U.S. Virgin Islands. Reliance Standard Life Insurance Company reserves the right to change the premiums it charges for its plans.