

ASO Choice Plus

Employees (Workers Compensation) Modified

Choice Plus plan gives you the freedom to see any Physician or other health care professional from the Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, your plan only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care CoordinationSM services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Hearing screenings are covered.

Vision is covered under United Vision Plan.

Choice Plus Benefits Summary

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
<p>This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. More complete descriptions of Benefits and the terms under which they are provided are contained in the Summary Plan Description that you will receive upon enrolling in the Plan.</p> <p>If this Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the Summary Plan Description shall prevail.</p> <p>Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.</p> <p>Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law.</p> <p>Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician.</p> <p>*Prior Notification is required for certain services.</p>	<p>Annual Deductible: \$ 250 per Covered Person per calendar year, not to exceed \$750 for all Covered Persons in a family.</p> <p>Out-of-Pocket Maximum: \$1000 per Covered Person per calendar year, not to exceed \$3000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the SPD.</p> <p>Out-of-Pocket Cross Apply</p> <p>Maximum Plan Benefit: No Maximum Plan Benefit.</p>	<p>Annual Deductible: \$500 per Covered Person per calendar year, not to exceed \$1500 for all Covered Persons in a family.</p> <p>Out-of-Pocket Maximum: \$3000 per Covered Person per calendar year, not to exceed \$6000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the SPD.</p> <p>Out-of-Pocket Cross Apply</p> <p>Maximum Plan Benefit: \$1,000,000 per Covered Person.</p>
<p>1. Ambulance Services - Emergency only</p>	<p>Ground Transportation: 90% of Eligible Expenses</p> <p>Air Transportation: 90% of Eligible Expenses</p>	<p>Same as Network Benefit</p>
<p>2. Dental Services - Accident only</p>	<p>*90% of Eligible Expenses</p> <p>*Prior notification is required before follow-up treatment begins.</p>	<p>*70% of Eligible Expenses</p> <p>*Prior notification is required before follow-up treatment begins.</p>
<p>3. Durable Medical Equipment Network Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year.</p>	<p>80% of Eligible Expenses</p>	<p>Not Covered</p>
<p>4. Emergency Health Services</p>	<p>\$200 per visit</p>	<p>Same as Network Benefit</p> <p>*Notification is required if results in an Inpatient Stay.</p>
<p>5. Eye Examinations Eye exams for medical conditions only</p>	<p>\$15 for per visit for Primary Care</p> <p>\$30 per visit for Specialists.</p>	<p>70% of Eligible Expenses</p>
<p>6. Home Health Care Network Benefits are limited to 60 visits for skilled care services per calendar year.</p>	<p>80% of Eligible Expenses</p>	<p>Not Covered</p>
<p>7. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Plan.</p>	<p>90% of Eligible Expenses</p>	<p>*70% of Eligible Expenses</p>
<p>8. Hospital - Inpatient Stay</p>	<p>\$250 per day, up to 2 day maximum, then 90% of eligible expenses, after satisfying \$250 deductible.</p> <p>If your doctor is performing any of the procedures while in the hospital in a non-network provider, the whole event is not covered.</p>	<p>\$250 per day, up to 2 day maximum, then 70% of eligible expenses, after satisfying \$500 deductible.</p> <p>If you don't notify Care Coordination, there will be a pre-notification penalty of \$500</p>
<p>9. Injections Received in a Physician's Office</p>	<p>No copayment</p>	<p>\$10 per visit</p>
<p>10. Maternity Services</p>	<p>Same as 8, 11, 12 and 13</p> <p>No Copayment applies to Physician office visits for prenatal care after the first visit.</p>	<p>Same as 8, 11, 12 and 13</p> <p>*Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</p>

YOUR BENEFITS

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
11. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	90% of Eligible Expenses.	70% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment For mammography testing: No Copayment	70% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	90% of Eligible Expenses	70% of Eligible Expenses
Outpatient Therapeutic Treatments	90% of Eligible Expenses.	70% of Eligible Expenses
12. Physician's Office Services	\$15 for per visit for Primary Care \$30 per visit for Specialists.	70% of Eligible Expenses. No Benefits for preventive care. <ul style="list-style-type: none"> • Preventive medical care. (Pap Smear, PSA and Child immunizations) • Well-baby and well-child care. • Routine physical examinations. • Vision and hearing screenings.
13. Professional Fees for Surgical and Medical Services	90% of Eligible Expenses	70% of Eligible Expenses
14. Prosthetic Devices Network Benefits for prosthetic devices are limited to \$2,500 per calendar year.	80% of Eligible Expenses	Not covered
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
16. Rehabilitation Services -Outpatient Therapy Network and Non-Network Benefits are limited as follows: 40 visits of physical therapy; 40 visits of occupational therapy; 40 visits of speech therapy; 40 visits of pulmonary rehabilitation; and 40 visits of cardiac rehabilitation per calendar year.	\$20 per visit	70% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	90% of Eligible Expenses	*70% of Eligible Expenses
18. Transplantation Services	90% of Eligible Expenses If you don't notify Care Coordination, there will be a pre-notification penalty of \$500	Not covered.
19. Urgent Care Center Services	\$30 per visit	70% of Eligible Expenses
20. Pharmacy	Retail (Mandatory generic drugs): \$0 copay – generic \$25 copay – brand, preferred \$40 copay – brand, non-preferred Mail Order (Mandatory mail order for maintenance drugs after a 90 day retail period for new prescriptions, and mandatory generic drugs): \$0 copay – generic \$50 copay – brand, preferred \$80 copay – brand, non-preferred	Not covered.
Additional Benefits		
Mental Health and Substance Abuse Services – Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 20 visits per calendar year.	\$30 per individual visit \$25 per Group visit	70% of Eligible Expenses

YOUR BENEFITS

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
<p>Mental Health and Substance Abuse Services – Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 30 days per calendar year Inpatient or 60 days Residential Care Facility not to exceed 60 days.</p>	<p>\$250 per day, up to 2 day maximum, then 90% of eligible expenses, after satisfying \$250 deductible.</p>	<p>\$250 per day, up to 2 day maximum, then 70% of eligible expenses, after satisfying \$500 deductible.</p> <p>If you don't notify Care Coordination, there will be a pre-notification penalty of \$500</p>
<p>Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to 20 visits per calendar year.</p>	<p>\$30 per visit</p>	<p>70% of Eligible Expenses</p>
<p>Gastric Bypass</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Infertility</p>	<p>Not covered</p>	<p>Not covered</p>
<p>United Vision Plan For detail information, call 1-800-638-3120</p>	<p>Eye exam once every 12 months</p> <p>\$10 copay for exam</p> <p>\$25 copay for materials that applies toward the entire purchase of eyeglasses (lenses and frames or contacts in lieu of eyeglasses).</p>	

Except as may be specifically provided in Section 1 of the Summary Plan Description (SPD) or through a Rider to the Plan, the following are not covered:

A. Alternative Treatments

Acupressure; hypnosis; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the SPD for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the SPD.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the SPD.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the SPD (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments.

Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the SPD. Any solid organ transplant that is performed as a treatment for cancer.

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the SPD.

O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services.

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the SPD.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.

In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring.

Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

This summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Summary Plan Description for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Summary Plan Description, the Summary Plan Description prevails. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.