Villa Restaurant Group

BasicCare Program

Summary Plan Description of the

Villa Restaurant Group 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 2

GENERAL QUESTIONS 4

COBRA – EXTENDED COVERAGE 5

YOUR RIGHTS UNDER ERISA 6

BASICADVANTAGE TOTAL COVERAGE 8

ESSENTIAL COVERAGE 17

DENTAL COVERAGE 20

FILING A CLAIM 24

HIPAA NOTICE 25

ID CARDS 27

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

Eligible Employees:	All Employees.
Eligibility:	The first day of the month after completing 60 days of service.
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

ERISA INFORMATION

ERISA Plan Name:	Villa Restaurant Group BasicCare Program
Type of ERISA Plan:	Health and Welfare Benefits
ERISA Plan Number:	501
ERISA Plan Fiscal Year End:	As on file with the ERISA Plan Administrator
ERISA Plan Sponsor:	Villa Restaurant Group
ERISA Plan Administrator:	Connie Cafone Office Manager 25 Washington Street Morristown, NJ 07960 Phone: (973) 695-0949
Agent for Service:	ERISA Plan Administrator
Employer Identification #:	22-2913107

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.

FLORIDA REQUIREMENTS

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

General Questions:

1. The description of eligible dependents is expanded to include your unmarried children from age 26 through the end of the calendar year in which the child reaches age 30 provided they: (1) do not have a dependent of their own; (2) are residents of Florida or full-time or part-time students; and (3) are not provided coverage under any other health insurance policy or are not entitled to benefits under Title XVIII of the Social Security Act.

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

   An adopted, foster, or other child in court-ordered custody who is placed with you in compliance with state law while the BasicAdvantage Total Coverage is in force will be covered from the moment of placement in your home provided you file a petition to adopt. However, coverage shall begin at the moment of birth if you have entered into a written agreement to adopt the child prior to the child's birth, whether or not such agreement is enforceable. You should provide written notice within 31 days after the placement or birth of the child. If such timely notice is given, any required premium for the child will be charged beginning after the end of the notice period. If timely notice is not given, the applicable additional premium will be charged from the date of placement, or birth in the case of a newborn.

BasicAdvantage Total Coverage:

The description of what is a hospital is expanded to include birth centers that are licensed under state law and licensed institutions without surgical facilities that are primarily of a rehabilitative nature, provided the facility is also accredited by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, and such rehabilitation is specifically for treatment of physical disability.

Dental Coverage:

1. The exclusion regarding any type of temporomandibular joint (TMJ) dysfunctions does not apply.

2. The exclusion regarding Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law applies only when expenses are paid under any such laws.

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?
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. 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), preventive health services, as well as routine newborn care for the first 31 days. The child will remain covered 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 coverage is in force is covered for injury and sickness and 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 extends to BasicAdvantage Total Coverage, Essential Coverage and Dental Coverage. The employee must be enrolled in the specific coverage(s) in order for that coverage to be continued.

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.

YOUR RIGHTS UNDER ERISA

As a participant in the Benefit Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

What are my ERISA rights?
ERISA provides that all Benefit Program participants are entitled to:

- examine, without charge, at your Employer's office, all Benefit Program documents, including insurance contracts and copies of all documents filed by the ERISA Plan Administrator with the U.S. Department of Labor or the Internal Revenue Service, such as detailed annual reports and Benefit Program descriptions;
- obtain copies of all Benefit Program documents and other Benefit Program information upon written request to the ERISA Plan Administrator, who may make a reasonable charge for copies of the materials; and
- continue health care coverage for yourself or dependents if there is a loss of coverage under the Benefit Program as a result of a qualifying event (see the topic "COBRA – EXTENDED COVERAGE"). You or your dependents may have to pay for such coverage.

Review this booklet and the documents governing the Benefit Program for the rules governing your COBRA continuation coverage rights.

How long does it take to receive copies?
The ERISA Plan Administrator is required to provide you copies of requested materials within 30 days. If you do not receive the material within this time frame, you may file suit in federal court. In such a case, the court may require the ERISA Plan Administrator to provide the requested materials and pay you up to $110 a day until you receive them, unless the delay was beyond the control of the ERISA Plan Administrator.

What if I believe my rights have been denied?
ERISA imposes duties upon the people or companies who are responsible for the operation of the Benefit Program. These people or companies are referred to as Fiduciaries. Fiduciaries must act solely in the interest of you and your dependents, as Benefit Program participants. As the ERISA Plan Sponsor your Employer is a Fiduciary and, as such, must not discharge you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Benefit Program or exercising your rights under ERISA.

What if I believe that I have been discriminated against?
You have the right to file suit in a federal court if you think your Employer or anyone else is discriminating against

you or otherwise stopping you from exercising your rights under ERISA. If you win your lawsuit, the court may require the losing party to pay your legal costs and fees, in addition to whatever other penalties it may impose. However, if you lose, the court may order you to pay the costs and fees, (for example if it finds your claim was frivolous).

Is filing suit my only option?
No. If you have any questions or problems with the Benefit Program, you should first contact the ERISA Plan Administrator, who is also the agent for service of legal process. If the ERISA Plan Administrator does not satisfactorily help you, contact the nearest area office of the Pension and Welfare Benefits Administration, United States Department of Labor. This federal agency is responsible for enforcing the law under ERISA and will be able to give you guidance as to what your rights are and how you can enforce them.

Where can I get more information on my rights under ERISA?
If you have any questions about this statement or about your rights under ERISA or COBRA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or: The Division of Technical Assistance and Inquiries Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You can also visit the Employee Benefits Security Administration's website at www.dol.gov/ebsa.

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
Your 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 your 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 ERISA 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.

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.

SUMMARY PLAN DESCRIPTION
This booklet, together with the copy you made of the form you used to enroll, is a Summary 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 your 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 ERISA 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:	$500 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 $1,000; 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:	$4,000 per day; maximum of 1 daily benefit per coverage year
Injury:	$2,000 per day; maximum of 1 daily benefit per coverage year
Stroke:	$1,500 per day; maximum of 1 daily benefit per coverage year
Childbirth:	$1,500 per day; maximum of 1 daily benefit per coverage year
Heart Attack:	$3,000 per day; or
Heart Disease:	$1,500 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:	$70 per day; maximum of 5 daily benefits per coverage year
Consultation office visit:	$100 per day; maximum of 1 daily benefit per coverage year
Emergency Room doctor visit:	$75 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):	$150 per day; maximum of 1 daily benefit per coverage year

Computerized Tomography (CT) Scan:	$75 per day; maximum of 1 daily benefit per coverage year
All other radiology services:	$40 per day; maximum of 6 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 6 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 $1,000; 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 18 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.

What do Telemedicine and Teletherapy services cost?
Telehealth services are available at no additional cost. Teletherapy services are available after a $28 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
$1,000 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	$1,000
	Musculoskeletal System	
20937	Spinal Bone Autograft	$356
22554	Neck Spine Fusion	$1,000
22585	Additional Spinal Fusion	$714
22612	Lumbar Spine Fusion	$1,000
22845	Insert Spine Fixation Device	$1,000
27130	Total Hip Arthroplasty	$1,000
27447	Total Knee Arthroplasty	$1,000
	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	$891
33519	Coronary Artery Bypass, Three Venous Grafts	$1,000
33533	Coronary Artery Bypass, Single Arterial Graft	$1,000
33534	Coronary Artery Bypass, Two Arterial Grafts	$1,000
35301	Rechanneling of Artery	$1,000
36010	Place Catheter in Vein	$256
36216	Place Catheter in Artery	$580
	Digestive System	
43235	Upper Gastrointestinal Endoscopy	$306
43239	Upper Gastrointestinal Endoscopy, Biopsy	$361
43280	Laparoscopy, Fundoplasty	$1,000
44140	Partial Removal of the Colon	$1,000
44950	Appendectomy	$1,000
44970	Laparoscopy, Appendectomy	$1,000
45378	Diagnostic Colonoscopy	$458
45380	Colonoscopy and Biopsy	$547
47562	Laparoscopic Cholecystectomy	$1,000
47563	Cholecystectomy with Cholangiography	$1,000
49000	Exploration of the Abdomen	$1,000
49568	Hernia Repair with Mesh	$562
	Urinary System	
51840	Attach Bladder/Urethra	$1,000
52332	Cystoscopy and Treatment	$298
	Male/Female Genital System	
55845	Extensive Prostate Surgery	$1,000
57260	Repair of Vagina	$1,000
58100	Biopsy of Uterus Lining	$186
58150	Total Hysterectomy	$1,000
58260	Vaginal Hysterectomy	$1,000
58262	Vaginal Hysterectomy with Removal of Tube(s) and/or Ovary(s)	$1,000
58340	Catheter for Hysterography	$120
58550	Laparoscopy, Surgical with Vaginal Hysterectomy	$1,000

58720	Removal of Ovary/Tube(s)	$1,000
	Maternity Care and Delivery	
59120	Surgical Treatment of an Ectopic Pregnancy	$1,000
59400	Routine Obstetric Care including Vaginal Delivery and Antepartum & Postpartum Care	$1,000
59510	Routine Obstetric Care including Cesarean Delivery and Antepartum & Postpartum Care	$1,000
	Nervous System	
63030	Low Back Disk Surgery	$1,000
63050	Cervical Laminoplasty	$1,000
63048	Lumbar Laminectomy, each Additional Segment	$452
63075	Neck Spine Disk Surgery	$1,000

Sample Outpatient Surgical Schedule
$1,000 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	$1,000
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	$1,000
25600	Closed Treatment of Distal Radial Fracture	$589
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	$1,000
	Respiratory System	
30520	Repair of Nasal Septum	$1,000
31231	Nasal Endoscopy, Diagnostic	$398
31575	Diagnostic Laryngoscopy	$239
	Digestive System	
42820	Tonsillectomy and Adenoidectomy	$629
43235	Upper Gastrointestinal Endoscopy	$593
43239	Upper Gastrointestinal Endoscopy with Biopsy	$690
45330	Diagnostic Sigmoidoscopy	$281
45355	Surgical Colonoscopy	$433
45380	Colonoscopy and Biopsy	$951
45384	Colonoscopy with Removal of Tumor(s), Polyp(s)	$951
46600	Diagnostic Anoscopy	$174
47562	Laparoscopic Cholecystectomy	$1,000
49505	Repair Initial Inguinal Hernia, age 5 or over	$1,000
	Urinary System	
50590	Fragmenting of Kidney Stone	$1,000
51701	Insert Bladder Catheter	$108
51820	Revision of Urinary Tract	$1,000
52000	Cystoscopy	$403
52317	Remove Bladder Stone	$1,000
52330	Cystoscopy and Treatment	$970
	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	$534
58558	Hysteroscopy with Biopsy	$812
58662	Laparoscopy with Excision of Lesions	$1,000

	Nervous System	
64450	Injection, Anesthetic Agent, Peripheral Nerve or Branch	$217
64721	Carpal Tunnel Surgery	$886
	Eye and Ocular Adnexa System	
65222	Remove Foreign Body from the Eye	$158
66984	Removal of Cataracts, Stage One Procedure	$1,000
68761	Close Tear Duct Opening	$300
69210	Removal of Impacted Ear Wax	$107
69436	Create Eardrum Opening	$344

COVERED DIAGNOSIS CODES FOR BASICADVANTAGE TOTAL COVERAGE PLANS 1, 2 & 3

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 allowable 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 "allowable charges" mean?
Allowable charge means the lower of the actual or usual, customary and reasonable charge incurred by a Covered Person for a covered service.

"Usual, customary and reasonable" means the lower of charges made by:

a) a provider for services and supplies rendered to the majority of the provider's patients; or

b) the majority of providers within a community for the same or similar services or supplies, not to exceed the majority of prevailing fees within a community for such services or supplies, determined based on statistically valid charge data using generally accepted industry standards and practices.

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,customary and reasonable 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
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screening for adults 45 to 75
- Depression screening
- Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese
- Diet counseling for adults at higher risk for chronic disease
- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting
- Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
- Hepatitis C screening for adults age 18 to 79 years
- HIV screening for everyone age 15 to 65, and other ages at increased risk
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use
- Immunizations for adults — doses, recommended ages, and recommended populations vary: Chickenpox (Varicella), Diphtheria, Flu (influenza), Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Measles, Meningococcal, Mumps, Whooping Cough (Pertussis), Pneumococcal, Rubella, Shingles, Tetanus
- Lung cancer screening for adults 50 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
- Obesity screening and counseling
- 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 adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Tuberculosis screening for certain adults without symptoms at high risk

For Women

- Birth control: 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).
- Bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause
- Breast cancer chemoprevention counseling for women at higher risk
- Breast cancer genetic test counseling (BRCA) for women at higher risk
- Breast cancer mammography screenings; Every 2 years for women 50 and over; As recommended by a provider for women 40 to 49 or women at higher risk for breast cancer
- Breastfeeding 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) for women age 21 to 65
- Chlamydia infection screening for younger women and other women at higher risk
- 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
- Expanded tobacco intervention and counseling for pregnant tobacco users
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 weeks pregnant (or later) 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 everyone age 15 to 65, and other ages at increased risk
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative women at high risk for getting HIV through sex or injection drug use
- Maternal depression screening for mothers at well-baby visits
- 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
- Tobacco use screening and interventions

- Urinary incontinence screening for women yearly
- Urinary tract or other infection screening
- Well-woman visits to get recommended services for all women

For Children

- Alcohol, tobacco, and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children: Age 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: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Blood screening for newborns
- Depression screening for adolescents beginning routinely at age 12
- Developmental screening for children under age 3
- Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders
- Fluoride 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; and regular screenings for children and adolescents as recommended by their provider
- Height, weight and body mass index (BMI) measurements taken regularly for all children
- Hematocrit or hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for adolescents at higher risk
- HIV screening for adolescents at higher risk
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use
- Hypothyroidism screening for newborns
- Immunizations for children from birth to age 18 — doses, recommended ages, and recommended populations vary:
  Chickenpox (Varicella), Diphtheria, tetanus, and pertussis (DTaP), Haemophilus influenza type b, Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Inactivated Poliovirus, Influenza (flu shot), Measles, Meningococcal, Mumps, Pneumococcal, Rubella, Rotavirus
- Lead screening for children at risk of exposure
- Obesity screening and counseling
- Oral health risk assessment for young children from 6 months to 6 years
- Phenylketonuria (PKU) screening for newborns
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis: Age 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
- Well-baby and well-child visits

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

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.

What if I miss a deadline for filing or appealing any claim?
If you do not submit a claim on time, do not appeal on time, or do not otherwise follow the claims procedures, you 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 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.
- If you have elected BasicAdvantage Total Coverage and Essential Coverage, the VSP Access Plan Membership Card is included below.
- 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 AND ESSENTIAL 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.

reliancematrix

PERMANENT DENTAL IDENTIFICATION CARD

Company Name: **Villa Restaurant Group**

Group Number: **BCD005783**

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

4/04 00195

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