ASO Choice Plus Plan 063 Mod

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

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

Some of the Important Benefits of Your Plan:

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

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

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

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.
### Choice Plus Benefits Summary

<table>
<thead>
<tr>
<th>Types of Coverage</th>
<th>Network Benefits / Copayment Amounts</th>
<th>Non-Network Benefits / Copayment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. More complete descriptions of Benefits and the terms under which they are provided are contained in the Summary Plan Description that you will receive upon enrolling in the Plan. This Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the Summary Plan Description shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description. Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law. Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician. *Prior notification is required for certain services.</td>
<td>Annual Deductible: $500 per Covered Person per calendar year, not to exceed $1000 for all Covered Persons in a family.</td>
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<td></td>
<td>Out-of-Pocket Maximum: $1500 per Covered Person per calendar year, not to exceed $3000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. Deductibles, copays and coinsurance accumulate toward the Out of Pocket Maximum. <strong>Pharmacy copays accumulate to the OOP Maximum Plan Benefit:</strong> No Maximum Plan Benefit.</td>
<td>Out-of-Pocket Maximum: $3000 per Covered Person per calendar year, not to exceed $6000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. Deductibles, copays and coinsurance accumulate toward the Out of Pocket Maximum. <strong>Pharmacy copays apply to the OOP Maximum Plan Benefit:</strong> No Maximum Plan Benefit.</td>
</tr>
</tbody>
</table>

#### 1. Ambulance Services - Emergency only

- **Ground Transportation:** 20% of Eligible Expenses OR No Copayment
- **Air Transportation:** 20% of Eligible Expenses

#### 2. Dental Services - Accident only

- **20% of Eligible Expenses**
- *Prior notification is required before follow-up treatment begins.
- **Same as Network Benefit**
- *Prior notification is required before follow-up treatment begins.

#### 3. Durable Medical Equipment

- **20% of Eligible Expenses**
- **40% of Eligible Expenses**
- *Prior notification is required when the cost is more than $1,000

#### 4. Emergency Health Services

- **$150 per visit**
- **Same as Network Benefit**
- *Notification is required if results in an Inpatient Stay.

#### 5. Eye Examinations

- **Refractive eye examinations are limited to one every other calendar year from a Network Provider.**
- **$20 per visit**
- **40% of Eligible Expenses**
- Eye Examinations for refractive errors are not covered.
- **Same as Network Benefit**
- *Notification is required if results in an Inpatient Stay.

#### 6. Home Health Care

- **20% of Eligible Expenses**
- **40% of Eligible Expenses**
- *Prior notification is required when the cost is more than $1,000

#### 7. Hospice Care

- **20% of Eligible Expenses**
- **40% of Eligible Expenses**

#### 8. Hospital - Inpatient Stay

- **20% of Eligible Expenses**
- **40% per visit**
- **Same as 8, 11, 12 and 13**
- *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.

#### 9. Injections Received in a Physician’s Office

- **$20 per visit**
- **40% per injection**
- **Same as 8, 11, 12 and 13**

#### 10. Maternity Services

- **Same as 8, 11, 12 and 13**
- No Copayment applies to Physician office visits for prenatal care after the first visit.
- **Same as 8, 11, 12 and 13**

#### 11. Maternity Services

- **Same as 8, 11, 12 and 13**
- No Copayment applies to Physician office visits for prenatal care after the first visit.
- **Same as 8, 11, 12 and 13**

#### 12. Maternity Services

- **Same as 8, 11, 12 and 13**
- No Copayment applies to Physician office visits for prenatal care after the first visit.
- **Same as 8, 11, 12 and 13**

#### 13. Maternity Services

- **Same as 8, 11, 12 and 13**
- No Copayment applies to Physician office visits for prenatal care after the first visit.
- **Same as 8, 11, 12 and 13**

#### 14. Maternity Services

- **Same as 8, 11, 12 and 13**
- No Copayment applies to Physician office visits for prenatal care after the first visit.
- **Same as 8, 11, 12 and 13**
### Types of Coverage

#### Non-Network Benefits / Copayment Amounts

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Network Benefits / Copayment Amounts</th>
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<tbody>
<tr>
<td>11. Outpatient Surgery, Diagnostic and Therapeutic Services</td>
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<tr>
<td>Outpatient Surgery</td>
<td>20% of Eligible Expenses</td>
<td>40% of Eligible Expenses</td>
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<tr>
<td>Outpatient Diagnostic Services</td>
<td>For lab and radiology/Xray: No Copayment</td>
<td>40% of Eligible Expenses</td>
</tr>
<tr>
<td>Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine</td>
<td>20% of Eligible Expenses</td>
<td>40% of Eligible Expenses</td>
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<tr>
<td>Outpatient Therapeutic Treatments</td>
<td>For mammography testing: No Copayment</td>
<td>40% of Eligible Expenses</td>
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<tr>
<td>12. Physician’s Office Services</td>
<td>$20 per visit. No Copayment applies when a Physician charge is not assessed.</td>
<td>40% of Eligible Expenses</td>
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<tr>
<td>13. Professional Office Services</td>
<td>20% of Eligible Expenses</td>
<td>40% of Eligible Expenses</td>
</tr>
<tr>
<td>14. Prosthetic Devices</td>
<td>20% of Eligible Expenses</td>
<td>40% of Eligible Expenses</td>
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<tr>
<td>Benefits are limited as follows:</td>
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<td>Limited to a single purchase of each type of prosthetic device every three years.</td>
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<td>15. Reconstructive Procedures</td>
<td>Same as 8, 11, 12, 13 and 14</td>
<td>*Same as 8, 11, 12, 13 and 14</td>
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<tr>
<td>16. Rehabilitation Services - Outpatient Therapy</td>
<td>$20 per visit.</td>
<td>40% of Eligible Expenses</td>
</tr>
<tr>
<td>Network and Non-Network Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.</td>
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<tr>
<td>Unlimited visits Speech therapy.</td>
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<tr>
<td>Unlimited visits for Manipulative therapy.</td>
<td>50% Deductible does not apply.</td>
<td>50% Deductible does not apply.</td>
</tr>
<tr>
<td>Copayments or Coinsurance for Covered Health Services provided within the scope of a chiropractor’s licenses will not exceed 50% of the total cost of any single chiropractic service as defined by Missouri law.</td>
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<tr>
<td>17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</td>
<td>20% of Eligible Expenses</td>
<td>*40% of Eligible Expenses</td>
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<td>Network and Non-Network Benefits are limited to 60 days per calendar year.</td>
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<tr>
<td>18. Transplantation Services</td>
<td>*20% of Eligible Expenses</td>
<td>*40% of Eligible Expenses</td>
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<td>Benefits are limited to $30,000 per transplant.</td>
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<tr>
<td>19. Urgent Care Center Services</td>
<td>$50 per visit</td>
<td>40% of Eligible Expenses</td>
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#### Additional Benefits

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<tr>
<td>Mental Health and Substance Abuse Services – Outpatient</td>
<td>100% after you pay a $20 Copayment per visit</td>
<td>40% of Eligible Expenses</td>
</tr>
<tr>
<td>Must receive prior notification through the Mental Health/Substance Abuse Designee.</td>
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</tr>
<tr>
<td>Mental Health and Substance Abuse Services – Inpatient and Intermediate</td>
<td>20% of Eligible Expenses</td>
<td>40% of Eligible Expenses</td>
</tr>
<tr>
<td>Must receive prior notification through the Mental Health/Substance Abuse Designee.</td>
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</tbody>
</table>
Exclusions

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

A. Alternative Treatments
Acupressure; hypnotism; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

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

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

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

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

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

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

H. Mental Health/Substance Abuse
Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis. Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

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

I. Nutrition
Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Nutritional and electrolyte supplements, including infant formula and donor breast milk.

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

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

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

L. Reproduction
Health services and associated expenses for infertility treatments.

Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan
Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers’ compensation, no-fault automobile insurance, or similar legislation. If coverage under workers’ compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any such services. Benefits will not be paid for any such services, other than those described in Section 1 of the SPD, which are covered under workers’ compensation or similar legislation had that coverage been elected.

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

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

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

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

O. Travel
Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

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

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

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

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

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

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

In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation.

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

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

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

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis).

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

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

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