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<p>Article II ELIGIBILITY AND PARTICIPATION Enrollment Provisions PPO - UHC Page 3 HBS Page 2 EPO - UHC Page 4 HBS Page 2</p>	<p><u>ELIGIBILITY PROVISIONS</u></p> <p>Eligibility Effective Date for Eligible Employees (does not apply to University employees) The 1st day of the first pay period following receipt of a properly executed enrollment and required supporting documentation; provided the request is received within thirty-one (31) days of the date of hire. Enrollment shall be completed using the Self-service option or submitting a completed Benefits Enrollment Form to your Agency or ADOA.</p> <p>Eligibility Effective Date for Eligible University Employees The 1st day of the first month following receipt of a properly executed enrollment and required supporting documentation; provided the request is received within thirty-one (31) days of the date of hire. Enrollment shall be completed using an appropriate method of notification.</p> <p>Eligibility Effective Date for Eligible Retirees, Long Term Disability (LTD) Recipients, Former Elected Officials, and Surviving Spouses of participating Retirees, Employees eligible for normal retirement, LTD Recipients and Former Elected Officials. The first or the sixteenth day of the first month following the Plan's receipt of a completed enrollment form provided the request is received within thirty-one (31) calendar days of the qualifying event.</p>	<p>Standard Enrollment Period</p> <p>Eligibility Effective Date for Eligible Employees (does not apply to University employees) The 1st day of the first pay period following receipt of a properly executed enrollment and required supporting documentation; provided the request is received within thirty-one (31) days of the date of hire. Enrollment shall be completed using the Self-service enrollment option or submitting a completed Benefits Enrollment Form to your Agency or ADOA.</p> <p>Eligibility Effective Date for Eligible University Employees The 1st day of the first month following receipt of a properly executed enrollment and required supporting documentation; provided the request is received within thirty-one (31) days of the date of hire. Enrollment shall be completed using an appropriate method of notification.</p> <p>Eligibility Effective Date for Eligible Retirees, Long Term Disability (LTD) Recipients, Former Elected Officials, and Surviving Spouses of participating Retirees, Employees eligible for normal retirement, LTD Recipients and Former Elected Officials.</p> <p>The first payroll cycle following the end of active coverage for active employees. For non-active employees the 1st of the month following the Plan's receipt of a completed enrollment form provided the request is received within thirty-one (31) calendar days of the qualifying event.</p>
<p>Article II ELIGIBILITY AND PARTICIPATION</p>	<p>Court Order A change in coverage due to and consistent with a</p>	<p>Medical Child Support Order under sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1988</p>

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Enrollment Provisions PPO - UHC Page 5 HBS Page 3 EPO - UHC Page 5 HBS Page 3	qualified medical child support order (QMCSO) of the Employee or other person to cover an Eligible Dependent or Spouse to which the Employee is legally married as defined by Arizona Revised Statute. A court order does not, in any way, override or provide exceptions to the services covered or excluded under this plan.	A change in coverage due to and consistent with a qualified medical child support order (QMCSO) of the Employee or other person to cover an Eligible Dependent or Spouse to whom the Employee is legally married as defined by Arizona Revised Statute. A court order does not, in any way, override or provide exceptions to the services covered or excluded under this plan.
Article II ELIGIBILITY AND PARTICIPATION Qualified Life Events PPO - UHC Page 5 HBS Page 4 EPO - UHC Page 4 HBS Page 4	<p>Medicare Eligibility/Entitlement When a Retiree, LTD, Former Elected Official, Surviving Spouse or and eligible dependent becomes Medicare Eligible either by age or disability, payment of the health insurance claims will be coordinated with Medicare as primary and the Plan secondary. It is the Members responsibility to notify the Plan when he/she becomes Medicare eligible.</p> <p>The Member may cancel or reduce coverage due to entitlement to Medicare, or may enroll or increase coverage due to loss of Medicare eligibility. The Effective Date will be the first of the month following ADOA's receipt for the request to change coverage.</p>	<p>Medicare Eligibility/Entitlement When a Retiree, LTD, Former Elected Official, Surviving Spouse or an eligible dependent becomes Medicare Eligible either by age or disability, payment of the health insurance claims will be coordinated with Medicare as primary and the Plan secondary. It is the Member's responsibility to notify the Plan when he/she becomes Medicare eligible.</p> <p>The Member may cancel or reduce coverage due to entitlement to Medicare, or may enroll or increase coverage due to loss of Medicare eligibility. The Effective Date will be the first of the month following ADOA's receipt of the paperwork.</p>
Article II ELIGIBILITY AND PARTICIPATION EFFECTIVE DATES FOR QUALIFIED LIFE EVENTS CHANGES PPO - UHC Page7 HBS Page 6 EPO - UHC Page 4 HBS Page 6	<p>For non-University Employees: Coverage is effective on the 1st day of the first pay period unless the Employee requests the effective date be delayed until the 1st of the following month.</p> <p>For University Employees: A completed Benefits Enrollment Form submitted to your University Human Resources office from the 1st day of the month through the 15th day of the month will be effective on the 16th of the</p>	<p>Updated</p> <p><u>EFFECTIVE DATES FOR QUALIFIED LIFE EVENTS CHANGES</u></p> <p>Excluding a Change in number of dependents due to birth, placement for adoption, legal guardianship;</p> <p>Coverage is effective as noted below following receipt of a properly executed enrollment and required supporting documentation; provided the request is received within thirty-one</p>

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		<p>month unless the Employee requests the effective date be delayed until the 1st of the following month.</p> <p>A completed Benefits Enrollment Form submitted to your University Human Resources office from the 16th day of the month through the last day of the month will be effective on the 1st of the following month.</p> <p>Eligibility Effective Date for Eligible Retirees, Long Term Disability (LTD) Recipients, Former Elected Officials, and Surviving Spouses of participating Retirees, Employees eligible for normal retirement, LTD Recipients and Former Elected Officials.</p> <p>The first or the sixteenth day of the first month following the Plan's receipt of a completed enrollment form provided the request is received within thirty-one (31) calendar days of the qualifying event.</p>	<p>(31) days of the Qualified Life Event.</p> <p>Eligibility Effective Date for Eligible Employees (does not apply to University employees) The 1st day of the first pay period following receipt of a properly executed enrollment and required supporting documentation.</p> <p>Eligibility Effective Date for Eligible University Employees Effective dates for University employees can not be made prior to the Qualified Life Event. The effective dates of coverage may be based on the University payroll schedule. Consult with your Human Resources Office to determine the effective date of change and for the documentation you are required to submit.</p> <p>Eligibility Effective Date for Eligible Retirees, Long Term Disability (LTD) Recipients, Former Elected Officials, and Surviving Spouses of participating Retirees, Employees eligible for normal retirement, LTD Recipients and Former Elected Officials. The 1st of the month following the Plan's receipt of a completed enrollment form.</p>
	<p>Article II - Eligibility and Participation (Eligibility Effective Date for Newborns) PPO - UHC Page 7 HBS Page 6 EPO - UHC Page 8 HBS Page 6</p>	<p>Eligibility Effective Date for Newborns Any Eligible Dependent child of the Eligible Employee or Employee's Legal Spouse born while the Employee is covered under the Plan will become covered under the Plan on the date of his/her birth if the Employee has family coverage. Coverage for the child will end on the 31st day if the Employee does not provide their Agency or ADOA with written notification within thirty-one (31) days of the date of birth. If single coverage is in effect at the time of birth, and the Employee does not elect to cover their newborn child within</p>	<p>Re-word:</p> <p>Any Eligible Dependent child of the Eligible Employee or Employee's Legal Spouse born while the Employee is covered under the Plan will become covered under the Plan on the date of his/her birth. Coverage for the child will end on the 31st day if the Employee does not provide their Agency or ADOA with written notification within thirty-one (31) days of the date of birth.</p> <p>If the Employee provides their Agency or ADOA with the written notification within thirty-one (31) days of the date of</p>

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		<p>thirty-one (31) days of the birth, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable. If single coverage is in effect and the Employee elects to cover the newborn child within thirty-one (31) days of the birth, coverage for that child will become effective the date of the child's birth.</p>	<p>birth , coverage for that child will become effective the date of the child's birth.</p>
	<p>Article II - Eligibility and Participation Eligibility Effective Date for Foster Care Placement PPO - UHC Page 8 HBS Page 7 EPO - UHC Page 9 HBS Page 7</p>	<p>An Eligible Dependent of the Employee placed by a court order in a foster care arrangement while the Employee is covered for Medical Insurance will become covered for Medical Insurance as follows provided enrollment is within thirty-one (31) days of the date of placement:</p> <p>For non-University Employees: Coverage is effective on the 1st day of the first pay period unless the Employee requests the effective date be delayed until the 1st of the following month.</p> <p>For University Employees: A completed Benefits Enrollment Form submitted to your University Human Resource office from the 1st day of the month through the 15th day of the month will be effective on the 16th of the month unless the Employee requests the effective date be delayed until the 1st of the following month.</p> <p>A completed Benefits Enrollment Form submitted to your University Human Resource office from the 16th day of the month through the last day of the month will be effective on the 1st of the following</p>	<p>An Eligible Dependent of the Employee placed by a court order in a foster care arrangement while the Employee is covered for Medical Insurance will become covered for Medical Insurance as follows provided enrollment is within thirty-one (31) days of the date of placement:</p> <p>For non-University Employees: Coverage is effective on the 1st day of the first pay period unless the Employee requests the effective date be delayed until the 1st of the following month.</p> <p>For University Employees: A completed Benefits Enrollment Form submitted to your University Human Resource office from the 1st day of the month through the 15th day of the month will be effective on the 16th of the month unless the Employee requests the effective date be delayed until the 1st of the following month.</p> <p>A completed Benefits Enrollment Form submitted to your University Human Resource office from the 16th day of the month through the last day of the month will be effective on the 1st of the following</p>

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<p>Article II - Eligibility and Participation Eligibility Eligibility Effective Date for Spouses PPO - UHC Page 9 HBS Page 7 EPO - UHC Page 10 HBS Page 7</p>	<p>An Eligible Spouse of the Employee entering into marriage while the Employee is covered under this Plan will become covered for Medical Insurance as follows provided enrollment is within thirty-one (31) days of the date of marriage:</p> <p>For non-University Employees: Coverage is effective on the 1st day of the first pay period unless the Employee requests the effective date be delayed until the 1st of the following month.</p> <p>For University Employees: A completed Benefits Enrollment Form submitted to your University Human Resource office from the 1st day of the month through the 15th day of the month will be effective on the 16th of the month unless the Employee requests the effective date be delayed until the 1st of the following month.</p> <p>A completed Benefits Enrollment Form submitted to your University Human Resource office from the 16th day of the month through the last day of the month will be effective on the 1st of the following month.</p>	<p>Employee is covered under this Plan will become covered for Medical Insurance as follows provided enrollment is within thirty-one (31) days of the date of marriage:</p> <p>For non-University Employees: The 1st day of the first pay period following receipt of a properly executed enrollment and required supporting documentation.</p> <p>For University Employees: Effective dates for University employees can not be made prior to the Qualified Life Event. The effective dates of coverage may be based on the University payroll schedule. Consult with your Human Resources Office to determine the effective date of change and for the documentation you are required to submit.</p> <p>For Eligible Retirees, Long Term Disability (LTD) Recipients, Former Elected Officials, and Surviving Spouses of participating Retirees, Employees eligible for normal retirement, LTD Recipients and Former Elected Officials: The 1st of the month following the Plan's receipt of a completed enrollment form.</p>
<p>Article II - Eligibility and Participation Termination of Coverage PPO - UHC Page 10 HBS Page 9 EPO - UHC Page 11 HBS Page 9</p>	<p>ELIGIBILITY DUE TO INDUSTRIAL LEAVE WITHOUT PAY The insurance coverage of an individual on leave without pay who fails to pay insurance premiums or contributions when due shall terminate at 12:00 midnight on the last day of the period covered by the last premium or contribution paid.</p> <p>ELIGIBILITY DUE TO NON-OCCUPATIONAL</p>	<p>ALL REFERENCES OF 12 MIDNIGHT HAVE BEEN CHANGED TO 11:59 PM.</p>

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	<p>LEAVE The insurance coverage of an individual on leave without pay who fails to pay insurance premiums or contributions when due shall terminate at 12:00 midnight on the last day of the period covered by the last premium or contribution paid.</p> <p>ELIGIBILITY DUE TO MILITARY LEAVE The insurance coverage of an individual on leave without pay who fails to pay insurance premiums or contributions when due shall terminate at 12:00 midnight on the last day of the period covered by the last premium or contribution paid.</p>	
<p>Article II - Eligibility and Participation Termination of Coverage PPO - UHC Page 11 HBS Page 9 EPO - UHC Page 12 HBS Page 9</p>	<p>For a Dependent A Dependent's coverage under this Plan will terminate at the earliest of the following times:</p> <ol style="list-style-type: none"> 1. At the earliest of any time when coverage ceases for the covered Employee. 2. For any Dependent whose coverage has been continued under COBRA, at 12:00 midnight on the last day that the Dependent is eligible for such coverage. 3. At 12:00 midnight on the last day of the month in which a Dependent child reaches the limiting age (19) for non-student Dependents. 4. At 12:00 midnight on the last day of the month in which a Dependent child, who has already reached the limiting age for non-student Dependents, ceases to be a Full-Time Student. If a Dependent child ceases classes for a period longer than one school term, termination is retroactive to the last day of the month in which the classes ceased. 	<p>ALL REFERENCES OF 12 MIDNIGHT HAVE BEEN CHANGED TO 11:59 PM.</p>

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	<p>5. At 12:00 midnight on the last day of the month in which a Dependent child, who is a Full-Time Student, reaches the limiting age (25) for Student Dependents.</p> <p>6. At 12:00 midnight on the date when a Dependent child is legally married.</p> <p>7. At 12:00 midnight on the date that a Dependent becomes an active member of the armed forces of any country other than the United States of America.</p> <p>8. At 12:00 midnight on the date when the Employee is relieved of a court-ordered obligation to furnish health care coverage for a child.</p> <p>9. At 12:00 midnight on the date when a covered Dependent Spouse is legally separated under a decree of dissolution of marriage or of separate maintenance or divorced from the covered Employee; or their marriage is legally annulled or dissolved.</p> <p>10. At 12:00 midnight on the date of the Dependent's death.</p>	
<p>Article II - Eligibility and Participation Termination of Coverage PPO - UHC Page 12 HBS Page 10 EPO - UHC Page 12 HBS Page 10</p>	<p>For a Retiree, LTD Member or Surviving Spouse A Member's coverage under this Plan will terminate at the earliest of the following times:</p> <p>1. For any Member who fails to remit required premiums for his/her coverage when due, at the end of the period for which the last contribution was made or as agreed upon by the Plan.</p> <p>2. For a Retiree, at 12:00 midnight on the last day in which coverage in an eligible class ceases.</p>	<p>For a Retiree, LTD Member or Surviving Spouse A Member's coverage under this Plan will terminate at the earliest of the following times:</p> <p>1. For any Member who fails to remit required premiums for his/her coverage when due, at the end of the period for which the last contribution was made or as agreed upon by the Plan.</p> <p>2. For a Retiree, at 11:59pm on the last day in which coverage in an eligible class ceases.</p>

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	<p>3. For any Retiree whose coverage has been extended under the provisions set forth in this Plan Description 12:00 midnight on the last day that the Retiree is eligible for coverage through such an extension of coverage. For an LTD participant, at 12:00 midnight on the last day of the month in which the disability ends.</p> <p>4. At 12:00 midnight on the date that this Plan is terminated.</p>	<p>3. For any Retiree whose coverage has been extended under the provisions set forth in this Plan Description 11:59pm on the last day that the Retiree is eligible for coverage through such an extension of coverage.</p> <p>4. For an LTD participant, at 11:59pm on the last day of the month in which the disability ends.</p> <p>5. At 11:59pm on the date that this Plan is terminated.</p>
<p>Article II - Eligibility and Participation Reinstatement of Coverage PPO - UHC Page 24 HBS Page 23 EPO - UHC Page 25 HBS Page 23</p>	<p><u>ELIGIBILITY DUE TO FAMILY MEDICAL LEAVE ACT (FMLA)</u> An Employee who is on approved FMLA leave is eligible to participate in the Plan by paying the employee contribution for medical coverage.</p> <p>The medical coverage of an individual on FMLA who fails to pay insurance premiums or contributions when due shall terminate at 12:00 midnight on the last day of the period covered by the last premium or contribution paid.</p> <p><u>ELIGIBILITY DUE TO INDUSTRIAL LEAVE WITHOUT PAY</u> An Employee who is on leave without pay due to an industrial illness or injury may continue to participate in the Plan for a maximum of six (6) months from the date of illness or injury by paying the employee contribution for medical coverage.</p> <p>At the end of the 6-month period, an Employee who remains on leave without pay due to industrial illness or injury may continue to participate in the Plan by paying both the State and Employee</p>	<p>ALL REFERENCES OF 12 MIDNIGHT HAVE BEEN CHANGED TO 11:59 PM.</p>

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		<p>contributions until the Employee returns to work or is determined to be eligible for Medicare coverage or Long-term Disability, whichever occurs first.</p> <p>The insurance coverage of an individual on leave without pay who fails to pay insurance premiums or contributions when due shall terminate at 12:00 midnight on the last day of the period covered by the last premium or contribution paid.</p> <p><u>ELIGIBILITY DUE TO NON-OCCUPATIONAL LEAVE</u></p> <p>An Employee who is on leave without pay for a health related reason that is not an industrial illness or injury may continue to participate in the Plan by paying both the State and Employee contribution.</p> <p>Eligibility to continue participation in the Plan shall terminate on the earliest of:</p> <ol style="list-style-type: none"> 1. Receipt of long-term disability benefits for which there is eligibility to continue the Plan participation under A.A.C. R2-5-418(A)(3); 2. A determination of eligibility for Medicare coverage; or 3. Thirty (30) months after the incapacity began. <p>An Employee who is on leave without pay for other than a health-related reason may continue to participate in the Plan for a maximum of six (6) months by paying both the State and the Employee</p>	
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		<p>contributions.</p> <p>The insurance coverage of an individual on leave without pay who fails to pay insurance premiums or contributions when due shall terminate at 12:00 midnight on the last day of the period covered by the last premium or contribution paid.</p> <p><u>ELIGIBILITY DUE TO MILITARY LEAVE</u></p> <p>An Employee who is on leave without pay due to entering military service, may continue to participate in the Plan for a maximum of twenty-four (24) months by paying both the State and the Employee contributions. An Employee on military leave for less than thirty-one (31) days will not be required to pay more than the active Employee contributions for that period of time.</p> <p>Te insurance coverage of an individual on leave without pay who fails to pay insurance premiums or contributions when due shall terminate at 12:00 midnight on the last day of the period covered by the last premium or contribution paid.</p>	
	<p>Article III – Pre-Authorization and Notification for Medical Services and Prescription Medication Termination of Coverage EPO - HBS Page 27</p>	<p>PRE-CERTIFICATION AND NOTIFICATION FOR MEDICAL SERVICES AND PRESCRIPTION MEDICATION</p> <p>Pre-certification is the process of determining the Medical Necessity of services before the services are incurred. This ensures that any medical care a member receives meets the Medical Necessity requirements of the Plan. The definition and requirements of Medical Necessity are identified in Article XVI. Pre-Certification is initiated by</p>	<p>Added</p> <p>Pre-certification is the process of determining the Medical Necessity of services before the services are incurred. This ensures that any medical care a member receives meets the Medical Necessity requirements of the Plan. The definition and requirements of Medical Necessity are identified in Article XVI. Pre-Certification is initiated by calling the toll-free Pre-Certification phone number shown on the back of your ID card and providing information on the planned medical services. Pre-</p>

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		<p>calling the toll-free Pre-Certification phone number shown on the back of your ID card and providing information on the planned medical services. Pre-Certification may be requested by you, your dependent or your Physician. However, the Member is ultimately responsible to ensure Pre-Certification is obtained.</p> <p>All decisions regarding medical care are up to a Patient and his/her Physician. There may be circumstances when a Patient and his/her Physician determine that medical care, which is not covered by this Plan, is appropriate. The Plan Sponsor and the Plan Administrator do not provide or ensure quality of care.</p>	<p>Certification may be requested by you, your dependent or your Physician. However, the Member is ultimately responsible to ensure Pre-Certification is obtained.</p> <p>All decisions regarding medical care are up to a Patient and his/her Physician. There may be circumstances when a Patient and his/her Physician determine that medical care, which is not covered by this Plan, is appropriate. The Plan Sponsor and the Plan Administrator do not provide or ensure quality of care.</p> <p><u>Pre-certification should be initiated for specific services are noted in the Plan Description by calling toll-free 1-888-999-1459 and providing information on the planned medical services. The patient or the physician/facility may request pre-certification; however, the member is ultimately responsible to ensure pre-certification is obtained.</u></p> <p><u>If Pre-certification is not obtained before planned medical services are incurred, the submitted claim will pend and a letter will be issued notifying you and the provider that pre-certification is required before claim processing can continue. This must be initiated by calling 1-888-999-1459 and providing information on the incurred medical services. If pre-certification is not initiated within 60 days of the first pend letter, the claim will be denied.</u></p>
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	Article III – Pre-Authorization and Notification for Medical Services and Prescription Medication Other Services and Supplies Termination of Coverage EPO - UHC Page 31 HBS Page 27	Services that should be Pre-Certified include, but are not limited to:	Add a new number 3, and move other numbers down. #3 To Read - A separate Pre-authorization is required for a newborn in cases where the infant has been diagnosed with a medical condition requiring in-patient services independent of the maternity stay.
	Article III – Pre-Authorization and Notification for Medical Services and Prescription Medication Other Services and Supplies Termination of Coverage EPO - UHC Page 31	Outpatient and ambulatory magnetic resonance imaging (MRI/MRA), PET Scans, ECT, BEAM (Brain Electrical Activity Mapping), Gamma Knife Rental of Durable Medical Equipment costing more than \$1,000;	Deleted Items
	ARTICLE VI (OPEN ACCESS TO PROVIDERS) EPO - HBS Page 34	OPEN ACCESS TO PROVIDERS Choosing a Primary Care Physician	OPEN ACCESS TO PROVIDERS DELETED Choosing a Primary Care Physician
	ARTICLE VII (SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES) PPO - UHC Page 36 HBS Page 33 EPO - UHC Page 39 HBS Page 35	Physician Visits (inpatient) Co-payment No charge	Physician Visits (General Practice, Family Practice and Internal Medicine, Chiropractor, Cardiac Therapy, Behavioral Health, Speech Therapy, Occupational Therapy, Respiratory Therapy and Physical therapy, OB/GYN, and Pediatrics) Co-payment \$10 All other specialists Co-payment \$20.00
	ARTICLE VII (SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES)	Periodic Routine Physical Exam Well-Child through age 1 (copay is waived if the only services rendered is a well-child immunization).	Periodic Routine Physical Exam Well-Child through age 1 (copay is waived if the only services rendered is a well-child immunization). Age 2 and over: 1 visit per Member per Plan Year and \$1500 per

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	PPO - UHC Page 37 HBS Page 34 EPO - UHC Page 40 HBS Page 36	Age 2 and over: 1 visit per Member per Plan Year and \$250 per Member per Plan Year (includes laboratory and radiology).	Member per Plan Year (includes laboratory and radiology).
	ARTICLE VII (SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES) PPO - UHC Page 37 HBS Page 34 EPO - UHC Page 40 HBS Page 36	Adult Immunizations (i.e. Pneumoc, flu) \$10.00 copay	Adult Immunizations Refer to page __ for a complete list of Adult Immunizatons.
	ARTICLE VII (SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES) PPO - UHC Page 38 HBS Page 35 EPO - UHC Page 40 HBS Page 36	Allergy Testing \$10.00 copay Antigen Administration Desensitization/treatment \$10.00 copay Family Planning Services Voluntary Tubal ligation (outpatient facility) No charge Vasectomy (physician's office) \$10.00 copay Implantable contraceptive products \$10.00 copay One per every five years Hospital Emergency Room. Must be a Medical Emergency as defined by the Plan. \$75.00 (waived if admitted directly from the emergency room) Out of Area Emergencies. Must be a Medical Emergency as defined by the Plan. Emergency Room \$75.00 (waived if admitted directly from the emergency room)	Allergy Testing \$20.00 copay Antigen Administration Desensitization/treatment \$20.00 copay Family Planning Services Voluntary Tubal ligation (outpatient facility) No charge Vasectomy (physician's office) \$20.00 copay Implantable contraceptive products \$20.00 copay One per every five years Hospital Emergency Room. Must be a Medical Emergency as defined by the Plan. \$125.00 (waived if admitted directly from the emergency room) Out of Area Emergencies. Must be a Medical Emergency as defined by the Plan. Emergency Room \$125.00 (waived if admitted directly from the emergency room)
	ARTICLE VII SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND	Mammography screening Age 35-39 one baseline Age 40 - 49 every two years	Mammography screening Age 35-39 one baseline Age 40-and older annually

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<p>SUPPLIES PPO - UHC Page 39 & 59 HBS Page 35 & 55 EPO - UHC Page 41 & 62 HBS Page 37 & 56</p>	<p>Age 50-and older annually Non-routine services covered more frequently based on recommendation of the Member's Physician.</p>	<p>Non-routine services covered more frequently based on recommendation of the Member's Physician.</p>
<p>ARTICLE VII SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES PPO - UHC Pg 41 & 60 HBS Pg 38 & 56 EPO - UHC Pg 44 & 63 HBS Pg 48 & 57</p>	<p>Medical Foods/Metabolic Supplements. Limited to \$5,000 per Member per Plan Year.</p> <p>Medical Foods / Metabolic Supplements Medical foods and metabolic supplements to treat inherited metabolic disorders or a permanent disease/non-functioning condition in which a Member is unable to sustain weight and strength commensurate with the Member's overall health status are covered.</p> <p>The Plan will cover up to 50% of the cost of medical foods prescribed to treat metabolic disorders covered under this Plan. There is a maximum Plan Year limit for medical foods of \$5,000 which applies to the cost of all prescribed modified low protein foods and metabolic formula.</p> <p>The following are not considered Medically Necessary and are not covered as a Metabolic Food / Metabolic Supplement:</p>	<p>Medical Foods/Metabolic Supplements. Limited to 75% to \$20,000 per Member per Plan Year.</p> <p>Medical Foods / Metabolic Supplements Medical foods and metabolic supplements to treat inherited metabolic disorders or a permanent disease/non-functioning condition in which a Member is unable to sustain weight and strength commensurate with the Member's overall health status are covered.</p> <p>The Plan will cover up to 75% of the cost of medical foods prescribed to treat metabolic disorders covered under this Plan. There is a maximum Plan Year limit for medical foods of \$20,000 which applies to the cost of all prescribed modified low protein foods and metabolic formula.</p> <p>The following are not considered Medically Necessary and are not covered as a Metabolic Food / Metabolic Supplement:</p>
<p>ARTICLE VII SCHEDULE OF MEDICAL BENEFITS PPO - UHC Page 41 HBS Page 38 EPO - UHC Page 44</p>	<p>New Entry</p>	<p>Smoking cessation aids both prescribed and over-the counter will be covered at a maximum of \$500 per lifetime per member. All co-pays based on the formulary will apply. Member must have a prescription and present to an in-network pharmacy for the aid to be</p>

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HBS Page 40		<p>covered. Only FDA approved aids will be covered.</p> <p>\$500 maximum per lifetime</p>
<p>ARTICLE VII SCHEDULE OF MEDICAL BENEFITS PPO - UHC Page 42 HBS Page 38 EPO - UHC Page 45 HBS Page 40</p>	New Entry	<p>Retail (90-day supply) Generic \$25.00 Copay Formulary Brand \$50.00 Copay Non-Formulary Brand \$100.00 Copay Infertility – oral medication \$100.00 Copay</p>
<p>ARTICLE VII Covered Expenses EPO HBS ONLY Page 44</p>	<p>If a Member uses Participating Providers for facility and physician services for a given procedure, any assistant surgeon, anesthesiologist, radiologist, and pathologist charges in connection with that procedure will be payable at the in-network level of benefits even if rendered by non-Participating Providers. During an inpatient admission, if a consultation is required by a specialist on call at the facility causing the member to have no control over the provider chosen, charges in connection with the consult will be payable at the in-network level of benefits even if rendered by non-Participating Providers. Covered charges will be reimbursed at in-network benefit levels subject to Reasonable and Customary rates. Any remaining balance may be subject to billing by non-Participating Providers and will be the responsibility of the Member.</p>	<p>If a Member uses Participating Providers for facility and physician services for a given procedure, any assistant surgeon, anesthesiologist, radiologist, and pathologist charges in connection with that procedure will be payable at the in-network level of benefits even if rendered by non-Participating Providers. During an inpatient admission, if a consultation is required by a specialist on call at the facility causing the member to have no control over the provider chosen, charges in connection with the consult will be payable at the in-network level of benefits even if rendered by non-Participating Providers. Covered charges will be reimbursed at in-network benefit levels subject to Reasonable and Customary rates.</p>
<p>ARTICLE VII SCHEDULE OF MEDICAL BENEFITS Cancer Clinical Trials PPO - UHC Page 48</p>	6. There is no clearly superior, non-investigational treatment alternative;	<p>6. There is no clearly superior, non-investigational treatment alternative;</p> <p>7. The available clinical or pre-clinical data provide a</p>

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<p>HBS Page 46 EPO - UHC Page 51 HBS Page 46</p>		<p>reasonable expectation that the treatment will be at least as efficacious as any non-investigational alternative; For the purposes of this specific covered service and benefit, coverage outside the State of Arizona will be provided under the following conditions: (a) The clinical trial treatment is curative in nature; (b) The treatment is not available through a clinical trial in the State of Arizona; (c) There is no other non-investigational treatment alternative;</p>
<p>ARTICLE VII SCHEDULE OF MEDICAL BENEFITS Durable Medical Equipment PPO - UHC Page 54 HBS Page 50 EPO - UHC Page 55 HBS Page 51</p>	<p>Purchase or rental of durable medical equipment is covered when ordered or prescribed by a Participating Physician and provided by a vendor approved by the Plan. Coverage for repair, replacement or duplicate equipment is not covered except when replacement or revision is necessary due to anatomical growth or a change in medical condition.</p> <p>Durable medical equipment is defined as:</p> <ol style="list-style-type: none"> 1. Generally for the medical or surgical treatment of an Illness or Injury, as certified in writing by the attending medical provider; 2. Serves a therapeutic purpose with respect to a particular Illness or Injury under treatment in accordance with accepted medical practice; 3. Items which are designed for and able to withstand repeated use by more than one person; 4. Is of a truly durable nature; 	<p>Purchase or rental of durable medical equipment is covered when ordered or prescribed by a Participating Physician and provided by a vendor approved by the Plan. The determination to either purchase or rent equipment will be made by the Plan. Coverage for repair, replacement or duplicate equipment is not covered except when replacement or revision is necessary due to anatomical growth or a change in medical condition.</p> <p>Durable medical equipment is defined as:</p> <ol style="list-style-type: none"> 7. Generally for the medical or surgical treatment of an Illness or Injury, as certified in writing by the attending medical provider; 8. Serves a therapeutic purpose with respect to a particular Illness or Injury under treatment in accordance with accepted medical practice; 9. Items which are designed for and able to withstand repeated use by more than one person; 10. Is of a truly durable nature; 11. Appropriate for use in the home; and 12. Is not useful in the absence of Illness or Injury. <p>Such equipment includes, but is not limited to, crutches, hospital</p>

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		<p>5. Appropriate for use in the home; and 6. Is not useful in the absence of Illness or Injury.</p> <p>Such equipment includes, but is not limited to, crutches, hospital beds, wheel chairs, respirators and dialysis machines.</p> <p>Unless covered in connection with the services described in the "Inpatient Services at Other Participating Health Care Facilities" or "Home Health Services" provisions, the following are specifically excluded:</p> <ol style="list-style-type: none"> 1. Hygienic or self-help items or equipment; 2. Items or equipment primarily used for comfort or convenience such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment; 3. Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines; 4. Institutional equipment, such as air fluidized beds and diathermy machines; 5. Elastic stockings and wigs; 6. Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, foot orthotics, braces and splints; 7. Items, such as auto tilt chairs, paraffin 	<p>beds (to maximum of \$5,000), wheel chairs, respirators and dialysis machines.</p> <p>Unless covered in connection with the services described in the "Inpatient Services at Other Health Care Facilities" or "Home Health Services" provisions, the following are specifically excluded:</p> <ol style="list-style-type: none"> 1. Hygienic or self-help items or equipment; 2. Items or equipment primarily used for comfort or convenience such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment; 3. Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines; 4. Institutional equipment, such as air fluidized beds and diathermy machines; 5. Elastic stockings and wigs; 6. Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, foot orthotics, braces and splints; 7. Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective; and 8. Items which under normal use would constitute a fixture to real property, such as lifts, ramps, railings, and grab bars. 9. Hearing aid batteries and chargers
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		<p>bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective; and</p> <p>8. Items which under normal use would constitute a fixture to real property, such as lifts, ramps, railings, and grab bars.</p>	
	<p>ARTICLE VII SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES Immunizations PPO - UHC Page 58 HBS Page 54 EPO - UHC Page 61 HBS Page 54</p>	<p>ARTICLE VII SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES Immunizations PPO - UHC Page 58 HBS Page 56 EPO - UHC Page 61 HBS Page 55</p>	<p>1. Influenza, Trivalent inactivated influenza vaccine (TIV) 2. Influenza, Live attenuated influenza vaccine (LAIV) 3. Pneumococcal poly-saccharide (PPV23) 4. Hepatitis B (Hep B) 5. Hepatitis A (Hep A) 6. Td (Tetanus, diphtheria) 7. Polio (IPV) 8. Varicella (Var) 9. Meningococcal Conjugate vaccine (MCV4) 10. MMR (Measles, mumps, rubella) 11. HPV Vaccine, Gardasil 12. Shingles Vaccine, Zoster</p>
	<p>ARTICLE VII SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES Residential Substance Abuse Treatment PPO - UHC Page 63 HBS Page 59 EPO - UHC Page 66 HBS Page 60</p>	<p>New Entry</p>	<p>Residential Substance Abuse Treatment Voluntary and court-ordered residential substance abuse treatment will be covered for a maximum of 30 days and limited to two treatments per plan year for chemical and alcohol dependency.</p>
	<p>ARTICLE VII SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES Substance Abuse Detoxification</p>	<p>Substance Abuse Detoxification Services Substance abuse detoxification services include detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs, and</p>	<p>Substance Abuse Detoxification Services Substance abuse detoxification services include detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs, and medication management when provided in conjunction with a</p>

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	Services PPO - UHC Page 63 HBS Page 59 EPO - UHC Page 67 HBS Page 60	medication management when provided in conjunction with a consultation. The Review Organization will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.	consultation. The Review Organization will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting. In-patient detoxification coverage is limited to two treatments per year and a lifetime maximum of five.
	ARTICLE VII SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES Excluded Mental Health and Substance Abuse Services PPO - UHC Page 63 HBS Page 59 EPO - UHC Page 67 HBS Page 60	11. Residential treatment;	Excluded Mental Health and Substance Abuse Services The following are specifically excluded from mental health and substance abuse services: 11. Residential treatment; (unless associated with chemical or alcohol dependency as described in the Residential Substance Abuse Treatment provisions)
	ARTICLE VII SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES Excluded Mental Health and Substance Abuse Services PPO - UHC Page 63 HBS Page 59 EPO - UHC Page 67 HBS Page 60	New Entry	16. Biofeedback is not covered for reasons other than pain management.
	ARTICLE VII SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES Organ Transplant Services PPO - UHC Page 67 HBS Page 60 EPO - UHC Page 69	New Entry	12. Kidney/liver

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	ARTICLE VII SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES Ostomy Supplies PPO - UHC Page 68 HBS Page 63 EPO - UHC Page 70 HBS Page 63	Ostomy Supplies Ostomy supplies are supplies which are medically necessary for care and cleaning of a temporary or permanent ostomy	Ostomy Supplies Ostomy supplies are supplies which are medically appropriate for care and cleaning of a temporary or permanent ostomy. Covered supplies include, but are not limited to pouches, face plates and belts, irrigation sleeves, bags and catheters, skin barriers, gauze, adhesive, adhesive remover, deodorant, pouch covers, and other supplies as appropriate
	ARTICLE VII SCHEDULE OF MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES Periodic Routine Health Examinations PPO - UHC Page 68 HBS Page 63 EPO - UHC Page 70 HBS Page 64	Periodic Routine Health Examinations age 2 and over, including vision and hearing screening, laboratory, and radiology services provided by a Physician limited to 1 visit per Member per Plan Year and \$250 maximum benefit paid per Member per Plan Year.	Periodic Routine Health Examinations age 2 and over, including immunizations, vision and hearing screening, laboratory, and radiology services provided by a Physician limited to 1 visit per Member per Plan Year and \$1500 maximum benefit paid per Member per Plan Year.
	ARTICLE VIII PRESCRIPTION DRUG BENEFITS PPO - UHC Page 71 HBS Page 65 EPO - UHC Page 73 HBS Page 66	New Entry	The Walgreens Health Initiatives Preferred Medication List (PML), also known as a formulary, is a list of medications that will allow you to maximize the value of your prescription benefit. These medications, chosen by a committee of doctors and pharmacists, are lower-cost generics and brand names that are available at a lower cost than their more expensive brand-name counterparts. The PML is updated quarterly, and as needed throughout the year to add significant new medications as they become available. Medications that no longer offer the best therapeutic value for the plan are deleted from the PML once a year, and a letter is sent to any member affected by the change. To see what medications are on the PML, log on to mywhi.com or contact the WHI Customer

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			<p>Care Center to have a copy sent to you. Sharing this information with your doctor helps ensure that you are getting the medications you need, and saving money for both you and your plan.</p> <p>COPAYMENT is that portion of Covered Prescription Drugs which you are required to pay under this benefit. In addition to the co-payments outlined below, members will be required to pay the difference in the medication cost of a generic medication versus a name-brand medication when the member requests the brand name drug and the prescribing physician has indicated the generic equivalent substitution is allowable. The plan will exclude Narrow Therapeutic Index (NTI) drugs from the copay penalties.</p>
	<p>ARTICLE VIII PRESCRIPTION DRUG BENEFITS PPO - UHC Page 72 HBS Page 66 EPO - UHC Page 74 HBS Page 67</p>	<p>New Entry</p>	<p>PARTICIPATING RETAIL COPAYMENT (up to a 90-day supply) An amount as follows for each Prescription Order: For Generic Drugs \$25 For Formulary Brand-Name Drugs \$50 For Non-Formulary Brand-Name Drugs \$100 For Infertility – Oral medications \$100</p> <p>No payment will be made under any other section for expenses incurred to the extent that benefits are payable for those expenses under this section.</p>
	<p>ARTICLE VIII PRESCRIPTION DRUG BENEFITS Covered Prescriptions Drugs PPO - UHC Page 72 HBS Page 66 EPO - UHC Page 74 HBS Page 67</p>	<p>3. Needles, syringes, glucose monitors, and machines, glucose test strips; visual reading ketone strips; urine test strips; lancets and alcohol swabs are all covered when dispensed by the mail order pharmacy program;</p>	<p>3. Needles, syringes, glucose monitors, and machines, glucose test strips; visual reading ketone strips; urine test strips; lancets and alcohol swabs are all covered when dispensed by the mail order and retail pharmacy program;</p>

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ARTICLE VIII PRESCRIPTION DRUG BENEFITS Reimbursement/Filing a Claim PPO - UHC Page 75 HBS Page 69 EPO - UHC Page 77 HBS Page 70	New Entry	Walgreens Health Initiatives Travel Within the United States Benefits are covered in-network. You may call 1.866.722.2141 to locate a pharmacy in the area in which you are traveling. International Travel Prescriptions cannot be mailed outside of the U.S. You may receive a one-year supply for certain prescriptions through mail-order service prior to leaving the U.S. Please call 1.800.345.1985 to make arrangements. If you obtain medications outside of the U.S., you will not be reimbursed.
ARTICLE IX EXCLUSIONS AND GENERAL LIMITATIONS PPO - UHC Page 79 HBS Page 72 EPO - UHC Page 81 HBS Page 73	20. Therapy to improve general physical condition including, but not limited to, routine, long term or non-medically necessary chiropractic care and rehabilitative services which are provided to reduce potential risk factors where significant therapeutic improvement is not expected.	20. Therapy to improve general physical condition including, but not limited to, routine long term care.
ARTICLE IX EXCLUSIONS AND GENERAL LIMITATIONS PPO - UHC Page 79 HBS Page 72 EPO - UHC Page 81 HBS Page 73	22. Private hospital rooms and/or private duty nursing unless determined to be Medically Appropriate by the Plan. Private duty nursing is considered Medically Appropriate only when skilled nursing is necessary and is not available from the facility in circumstances of inpatient hospitalization. Custodial Nursing is not covered by the Plan.	22. Private hospital rooms and/or private duty nursing are only available during inpatient stays and determined to be medically appropriate by the Plan. Private duty nursing is available only in an inpatient setting when skilled nursing is not available from the facility. Custodial Nursing is not covered by the Plan.
ARTICLE IX EXCLUSIONS AND GENERAL LIMITATIONS PPO - UHC Page 80 HBS Page 73 EPO - UHC Page 82	23. Artificial aids including, but not limited to, foot orthotics, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures, and wigs, except as provided in the Diabetic Services and Supplies provision of the Covered Service and Supplies Article of this plan.	23. Artificial aids including, but not limited to, foot orthotics, corrective orthopedic shoes, arch supports, elastic/ compression stockings, garter belts, corsets, dentures, and wigs, except as provided in the Diabetic Services and Supplies provision of the Covered Service and Supplies Article of this plan.

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	ARTICLE IX EXCLUSIONS AND GENERAL LIMITATIONS PPO - UHC Page 80 HBS Page 73 EPO - UHC Page 82 HBS Page 74	29. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.	29. Membership costs or fees associated with health clubs, and weight loss programs. Deleted and smoking cessation programs.
	ARTICLE IX EXCLUSIONS AND GENERAL LIMITATIONS PPO - UHC Page 81 HBS Page 74 EPO - UHC Page 83 HBS Page 75	New Entry	47. Manipulations under anesthesia. This does not include reductions of fractures and/or dislocations done under anesthesia 48. Surgery for correction of Hyperhidrosis.
	ARTICLE X COORDINATION OF BENEFITS AND OTHER SOURCES OF PAYMENT Claim Determination Period PPO - UHC Page 85 HBS Page 77 EPO - UHC Page 87 HBS Page 78	The Plan Year October 1 through September 30 but it does not include any part of a year during which you are not covered under this Plan or any date before this section or any similar provision takes effect.	The claim determination period corresponds to the Plan Year , but it does not include any part of a year during which you are not covered under this Plan or any date before this section or any similar provision takes effect
	ARTICLE XI CLAIM FILING PROVISION AND APPEAL PROCESS Claims Appeal Procedures PPO - UHC Page 96 EPO - UHC Page 98	New Entry	Appeals for prescription claims should be submitted to the following address: Walgreens Health Initiatives Attn: Appeals P.O. Box 269 Deerfield, IL 60015
	ARTICLE XVI DEFINITIONS PPO - UHC Page 111 HBS Page 99	ELIGIBLE DEPENDENT and DEPENDENT shall mean: 1. The Spouse of an Employee who is legally married to the Employee as defined by Arizona	ELIGIBLE DEPENDENT and DEPENDENT shall mean: 1. The Spouse of an Employee who is legally married to the Employee as defined by Arizona Revised Statute, who is not divorced from the Employee, or whose marriage to the Employee

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<p>EPO - UHC Page 114 HBS Page 101</p>	<p>Revised Statute, who is not divorced from the Employee, or whose marriage to the Employee has not been otherwise legally terminated;</p> <p>2. Each unmarried child of the Employee/Spouse, through 12:00 midnight on the last calendar day of the month of their nineteenth (19th) birthday who is: a. A natural son or daughter of the Employee; b. A stepchild whose primary place of residence is with the Employee; c. A child placed by court order in the Employee's home; d. A legally adopted child or a child to whom a court of competent jurisdiction has entered an interlocutory order of adoption; or e. The Employee is required to provide health care coverage for the child under a qualified medical child support order;</p> <p>3. Each unmarried child of an Employee who has attained their nineteenth (19th) birthday, through 12:00 midnight on the day on which he ceases to be a Full-Time Student at an accredited institution of higher learning but in no event beyond 12:00 midnight on the last calendar day of the month of their twenty-fifth (25th) birthday; and</p> <p>4. Each unmarried child of an Employee who has attained their nineteenth (19th) birthday who is mentally or physically handicapped based on the Social Security Administration guidelines and who is incapable of engaging in self-sustaining employment due to such incapacity. Application for such continuation of Dependent status must be made with the Plan Administrator within thirty-one (31) days of the child's 19th birthday (25th birthday in the case of a Full-Time Student). The Plan Administrator has the right to require proof of the continuation of such incapacity upon</p>	<p>has not been otherwise legally terminated; or</p> <p>2. Each unmarried child of the Employee/spouse, through 11:59pm on the last calendar day of the month of their nineteenth (19th) birthday who is:</p> <p>a. A natural son or daughter of the Employee;</p> <p>b. A stepchild whose primary place of residence is with the Employee;</p> <p>c. A child placed by court order in the Employee's home;</p> <p>d. A legally adopted child or a child to whom a court of competent jurisdiction has entered an interlocutory order of adoption; or</p> <p>e. The Employee is required to provide health care coverage for the child under a qualified medical child support order;</p> <p>3. Each unmarried child of an Employee who has attained their nineteenth (19th) birthday, through 11:59pm on the day before he ceases to be a Full-Time Student at an accredited institution of higher learning but in no event beyond 11:59 on the day before their twenty-fifth (25th) birthday; and</p>
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		attainment of age nineteen (19) or anytime thereafter as deemed necessary by the Plan Administrator.	
	ARTICLE XVI DEFINITIONS Plan Year PPO - UHC Page 122 HBS Page 111 EPO - UHC Page 124 HBS Page 109	New Entry	Any and all provisions revised in the plan document will become effective October 1 for actives and January 1 for retirees unless specified otherwise.
	ARTICLE XVI DEFINITIONS Plan Year PPO - HBS Page 113 EPO - HBS Page 111	REVIEW ORGANIZATION shall mean Schaller Anderson of Arizona, L.L.C.	REVIEW ORGANIZATION shall mean Medical Management Organization. Deleted Schaller Anderson of Arizona, L.L.C.