**From:** Lynda Walker [LWalker@darden.com]
**Sent:** Thursday, September 30, 2010 10:30 AM
**To:** HHS HealthInsurance (HHS)
**Subject:** waiver

**Attachments:** Darden Waiver Application.pdf; Darden Day One Medical.pdf; ATT00001..txt

Dear Mr. Mayhew,

Darden is applying for a waiver for our limited benefit plan, which we refer to as our Day 1 plan.

We have attached

- A signed Waiver Application for Darden's limited benefit plan
- A summary plan description for the plan, entitled "Summary Plan Description for Day One Medical and Prescription Drug Benefits Under the Darden Restaurants Group Life and Health Plan for Store Staff Employees

Please let me know if you have any questions or need any additional information.

Thank you for your consideration of our limited benefit plan, which provides access for more than 100,000 employees to affordable medical coverage.

Best regards,

Lynda

*Lynda Walker*
*Vice President, Total Rewards Design*
*1000 Darden Center Drive*
*Orlando, FL 32837*
*Telephone #: 407-245-6118*
*Fax #: 407-241-6158*

# Annual Dollar Limit Waiver Application for Self Insured Options

| | |
|---|---|
| **Employer Name** Darden Restaurants, Inc. | **EIN** 59-3305930 |
| **Employer Address** 1000 Darden Center Drive, Orlando, FL 32837 (phone: 407.245.4000) | |
| **Plan Option Name** Two Options: Day One Basic Plan and Day One Plus Plan | |

**Number of individuals covered (employees and dependents)**

Day One Basic Plan–Varies between (b)(4) to (b)(4) employees and additional (b)(4) to (b)(4) dependents

Day One Plus Plan– Varies between (b)(4) to (b)(4) employees and additional (b)(4) to (b)(4) dependents

**Summary Plan Description (SPD)**
The SPD, "Summary Plan Description for Day One Medical and Prescription Drug Benefits Under the Darden Restaurants Group Life and Health Plan for Store Staff Employees", is attached to the waiver application.

| **Annual Limit Amount** | **Rate Amount** |
|---|---|
| Day One Basic Plan–Plan pays (b)(4)% of Reasonable and Customary up to (b)(4) annually; Up to an additional (b)(4) for Wellness and (b)(4) for Prescriptions<br><br>Day One Plus Plan–Plan pays (b)(4)% of Reasonable and Customary up to $ (b)(4) annual maximum for in-patient stay ( (b)(4) maximum on other covered services); Up to an additional (b)(4) for Wellness and (b)(4) for Prescriptions | Weekly rates are shown below (assuming 52 weeks a year):<br><br>Format–Employee Only/Employee+One/Family<br>Day One Basic Plan–$ (b)(4) /$ (b)(4) /$ (b)(4)<br>Day One Plus Plan–$ (b)(4) /$ (b)(4) /$ (b)(4)<br><br>All rates are for 2011 and the rate frequency is weekly (again, assuming 52 weeks a year). |

**Brief Description of why compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans, or significant increase in premiums paid by those covered by such plans, along with any supporting documentation.**

In order to provide an affordable level of immediate (no waiting period) access to coverage to the vast majority of Darden's employees and their dependents, Darden has employed a Limited Medical Plan strategy dating back prior to 1997. These Limited Medical Plans provide an affordable option for access to first dollar medical and pharmacy coverage.

Removing Darden's ability to utilize a Limited Medical Plan strategy would eliminate this highly-appreciated, highly-valued, and affordable benefit from (b)(4) employees and dependents enrolled and (b)(4) others with the option to enroll today. To remove the Annual Maximums and move the population to a more traditional PPO option would result in employee's cost of coverage being (b)(4) times higher than what is required under the 2011 Limited Medical Plans Strategy.

Danielle L Kuyan — 9/28/10

**Plan Administrator Signature** **Date**

Attestation certifying (1) that the plan was in force prior to September 23, 2010; and (2) that the application of restricted annual limits would result in a significant decrease in access to benefits for those currently covered by the plan, or a significant increase in premiums paid by those covered by such plans or policies.

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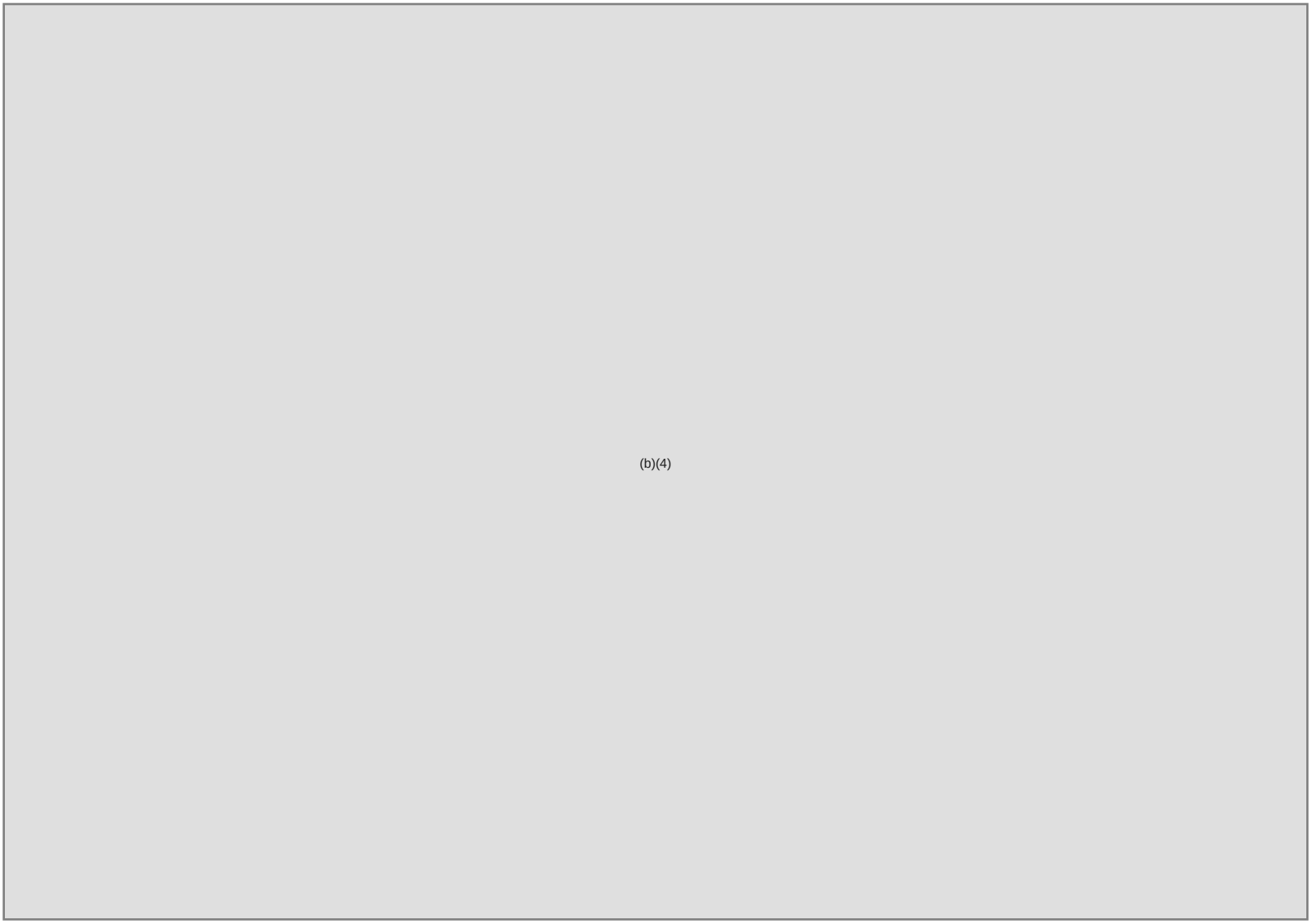


**SUMMARY OF DAY ONE BENEFITS**

**Day One Basic Option**

The Day One Basic option has a (b)(4) per-person deductible and a (b)(4) per-person annual Plan limit that can be used for any covered medical service, including hospitalization. Wellness coverage has a separate and additional (b)(4) per-person annual limit. The Day One Basic option requires you pay a modest dedu nd low fees for doctor office visits for you and your enrolled dependents. Once the Plan has paid (b)(4) on your behalf for medical expenses and (b)(4) for wellness expenses in a Plan Year, no more coverage for medical or wellness expenses will be provided for the remainder of the Plan Year. The Day One Basic option also includes a (b)(4) annual prescription benefit for each covered individual. With this coverage, you (i) pay a (b)(4)% co-insurance or minimum co-pays for prescriptions; (ii) can use mail order service for long-term maintenance medications to reduce costs; and (iii) can continue to access prescription network discounts after the annual $(b)(4) prescription benefit has been used, which may help lower your costs. This plan does not require prio tification for any services.

**Day One Plus Option**

The Day One Plus option provides the same basic coverage as the Day One Basic option (up to (b)(4) for medical and (b)(4) for wellness each Plan Year,) and provides an additional (b)(4) annual benefit for in-patient hospitalization only (this additional (b)(4) amount cannot be used atient services.) This Day One Plus option has an annual hospitalization deductible of (b)(4) that applies each time you or a

dependent are hospitalized, a n addition to the annual (b)(4) per-person deductible. The Day One Plus option similarly includes a (b)(4) annual prescription b for each covered individual. With this coverage, you (i) pay a (b)(4)% co-insurance or minimum co-pays for prescriptions; (ii) can use mail order service for long-term maintenance medications to reduce costs; and (iii) can continue to access prescription network discounts after the annual $(b)(4) prescription benefit has been used, which may help lower your costs. This plan does not require prio tification for any services.

**Day One Basic & Day One Plus Plan Differences**

In most cases, benefits in the Day One Basic and Day One Plus options are the same – $100 deductible, office visits, prescription drugs, wellness schedules, laboratory fees, maternity, etc. However, there are also key differences as outlined:

| | Day One Basic | Day One Plus |
|---|---|---|
| **Maximum benefit** | Plan pays $ (b)(4) annually. Prescriptions and wellness excluded from annual maximum; see covered services above. | Plan pays $ (b)(4) annual maximum for hospital stay (includes the (b)(4) Basic maximum available for covered services, excluding prescriptions and wellness). |
| **Hospital Admission Deductible** | (b)(4) | |
| **Inpatient Hospital Care (including maternity)** | You pay (b)(4)% of eligible charges after ded ible ( (b)(4) maximum). | You pay (b)(4)% of eligible charges after deductible ($ (b)(4) maximum, (b)(4) if Basic maximum has been exhausted). |
| **Emergency Care** | You pay (b)(4)% of eligible charges after annual deductible and separate $(b)(4) Emergency Room deductible. | You pay (b)(4)% of eligible charges after annual d ctible and separate $(b)(4) Emergency Room deductible.<br><br>$(b)(4) Emergency Room deductible is ved if admitted; then inpatient hospital admission deductible applies. |

**Covered Medical Services**

The following chart of covered services provides highlights of the Day One Basic and Day One Plus medical benefits available under the Plan**. This plan does not require prior notification for any services.**

| Benefit | Coverage |
|---|---|
| Allergy tests | (b)(4)% of reasonable and customary after deductible up to annual maximum. |
| Allergy treatment | (b)(4)% of reasonable and customary after deductible up to annual maximum. |
| Alternative medicine | Not covered. |
| Ambulance charges | (b)(4)% of reasonable and customary after deductible up to annual maximum. |
| Birth control pills | Covered like any other prescription drug. |
| CAT scans | (b)(4)% of reasonable and customary after deductible up to annual maximum. |
| Chiropractors | (b)(4)% of reasonable and customary after deductible up to (b)(4) in a calendar year. |

| Benefit | Coverage |
|---|---|
| Cosmetic surgery | Covered like any other surgery only if the result of:<br>• A medically-necessary mastectomy.<br>• A non-occupational accidental injury, or to correct a condition, including a birth defect, which impairs bodily function.<br>In compliance with Title IX, Women's Health and Cancer Rights, added to ERISA by the 1998 Omnibus Budget Bill, the following services complementing medical and surgical benefits for mastectomies, in a manner determined in consultation with the attending physician and the patient:<br>a) Reconstruction of the breast on which the mastectomy was performed;<br>b) Surgery or reconstruction of the other breast to produce a symmetrical appearance; and<br>c) Prostheses and physical complications with all states of the mastectomy, including lymph edemas.<br>All relevant Plan Provisions regarding annual deductibles, coinsurance, and copayments apply to these additional services. |
| Dental treatment | Covered only if treatment is for the excision of a malignant tumor or if required to repair or replace sound natural teeth damaged in an accident. Covers hospitalization if clinically appropriate. |
| Durable medical equipment | (b)(4)% of reasonable and customary after deductible up to annual maximum. |
| Emergency care | (b)(4)% of rea able and customary after the annual deductible of (b)(4) and a separate and additional (b)(4) Emergency Room deductible up to the annual pla ximum. Emergency Room ded ble will be waived upon admission. |
| Gynecology visits | (b)(4)% of reasonable and customary after (b)(4) co-pay up to (b)(4) maximum, if qualified under lan's wellness schedule. Deductible s not apply. Gynecological visits for treatment of a medical condition are covered like any other doctor office visit and not subject to the wellness schedule. |
| Hearing care | Not covered. |
| Home health care | (b)(4)% of reasonable and customary to annual maximum. Deductible does not apply. Maximum of $(b)(4) per visit up to (b)(4) visits per calendar year. |
| Hospice care | (b)(4)% of reasonable and customary. Deductib s not apply. Limit $(b)(4) per day. Maximum (b)(4) per year for inpatient care, (b)(4) per year for home care. |
| Hospital Outpatient Department or Ambulatory Surgical Facility | (b)(4)% of reasonable and customary up to annual plan maximum of $ (b)(4)<br>Eligible wellness services in a Hospital Outpatient Department or Ambulatory Surgical Fac would be paid at (b)(4)% of reasonable and customary up to the annual Wellness benefit of $(b)(4) |
| Hospital stay<br>(Additional (b)(4) inpatient benefit paid only if enrolled in Day One Plus) | (b)(4)% of reasonable and customary after applicable deductibles up to annual maximum. Inpatient hospital benefits are subject to annual plan maximum benefit of (b)(4) (Day One Basic) or (b)(4) (Day One Plus).<br>Covers the cost of a semiprivate room. Private rooms are covered up to the semiprivate room rate unless:<br>A private room is clinically appropriate<br>The hospital has only private rooms<br>Doctor visits during hospitalization are covered at (b)(4)% of reasonable and customary after deductible up to the annual maximum. |
| Immunizations | Per wellness schedule, covered at (b)(4)% to maximum of $(b)(4) per person per year. The deductible does not apply. Refer to wellness services for more information. |

| Benefit | Coverage |
|---|---|
| Infertility treatment | Not covered. |
| Laboratory charges | % of reasonable and customary after deductible up to annual maximum. (b)(4) |
| Magnetic Resonance Imaging - MRI | % of reasonable and customary after deductible up to annual maximum. |
| Mammograms | Per wellness schedule, covered at (b)(4)% to maximum of $(b)(4) per person per year. The deductible does not apply. Refer wellness services fo re information. |
| Mental health | Not covered. |
| Occupational therapy | (b)(4)% of reasonable and customary after deductible up to annual maximum. Subject to (b)(4) it limit per year that applies to all types of eligible therapy (combined limit). |
| Office visits | (b)(4)% of reasonable and customary after $(b)(4) co-pay up to annual maximum. Deductible does not apply. |
| Organ transplant | (b)(4)% of reasonable and customary after deductible up to annual maximum. |
| Pap smears | Per wellness schedule, covered at (b)(4)% to maximum of $(b)(4) per person per year. The deductible does not apply. Refer wellness services for more information. |
| Physical exams for adults | Per wellness s ule, covered (b)(4)% of reasonable and customary after $(b)(4) co-pay to maximum of $(b)(4) per person per year. The deductible does not apply. R r to wellness services for m nformation. |
| Physical exams for children | Per wellness schedule, covered (b)(4)% of reasonable and customary after $(b)(4) co-pay to maximum of $(b)(4) per person per year. The deductible does not apply. R r to wellness services for m nformation. |
| Physical therapy | (b)(4)% of reasonable and customary after deductible up to annual maximum. Subject to (b)(4) visit limit per year that applies to all types of eligible therapy (combined limit). |
| Pregnancy / Maternity<br>(Additional (b)(4) inpatient benefit paid only if enrolled in Day One Plus) | Doctor delivery charges covered (b)(4)% of reasonable a mary after deductible up to annual maximum of (b)(4) (Day One Basic) or (b)(4) (Day One Plus.) Routine prenatal visits and labs are included in the delivery charge.<br>Maternity hospital stay covered at (b)(4) of reasonable and customary after applicable deductibles up to annual maximum.<br>Newborn nursery charges d at (b)(4) of reasonable and customary after deductible up to annual maximum of (b)(4) (Da ne Basic) or (b)(4) (Day One Plus.) Also covered is the initial pediatric at (b)(4) of reasonable and customary, and circumcision at (b)(4) of reasonable and customary after deductible, up to the applicable annual maximum.<br>A child is covered at birth as long as the bab eets the dependent child eligibility requirements and is added to the plan within (b)(4) days of birth.<br>Midwife services are covered at the same level as a physician. A licensed birthing center is covered at the same rate as a hospital. These services are considered outpatient and are limited to the (b)(4) annual maximum. |

<table>
<tr><td rowspan="8">Prescription drugs</td><td colspan="2">You are eligible for up to (b)(4) in prescription coverage (per covered person) per calendar year. Use a pharmacy in the Medco Health Solution network for your best benefit. If you go outside the network, you pay a higher cost and have to pay up front and file a claim for reimbursement. Visit the Medco website at www.medco.com or call 1-800-875-3142.<br>Deductible does not apply. Once the plan has paid (b)(4) in prescription expenses, you will still be able to access network discounts which may help lower your cost.</td></tr>
<tr><td>Coverage</td><td>You Pay</td></tr>
<tr><td>Pharmacy Generic<br>Network</td><td>(b)(4) co-insurance (minimum (b)(4) co-pay) up to 30 day supply. After the third pharmacy refill, co-insurance increases to (b)(4)% and Mail Order may be a better option.</td></tr>
<tr><td>Pharmacy Generic<br>Out-Of-Network</td><td>(b)(4)% co-insurance (minimum (b)(4) co-pay) plus any amount over network rate up to 30 day supply. After the third pharmacy refill, co-insurance increases to (b)(4) and Mail Order may be a better option.</td></tr>
<tr><td>Pharmacy Brand<br>Network</td><td>(b)(4)% co-insurance for a non-maintenance drug (minimum (b)(4) co-pay) /<br>(b)(4)% co-insurance for a maintenance drug (minimum (b)(4) co-pay) up to 30 day supply.</td></tr>
<tr><td>Pharmacy Brand<br>Out-Of-Network</td><td>(b)(4)% co-insurance for a non-maintenance drug (minimum (b)(4) co-pay) /<br>(b)(4)% co-insurance for a maintenance drug (minimum (b)(4) co-pay) plus any amount over the network rate up to 30 day supply.</td></tr>
<tr><td>Mail Order Generic</td><td>(b)(4) co-insurance (minimum (b)(4) co-pay) up to 90 day supply. (b)(4) imum per prescription.</td></tr>
<tr><td>Mail Order Brand</td><td>(b)(4)% co-insurance (minimum (b)(4) co-pay) up to 90 day supply. (b)(4) ximum per prescription.</td></tr>
<tr><td>Prostate Specific Antigen test - PSA</td><td colspan="2">Per wellness schedule, covered at (b)(4)% to maximum of $(b)(4) per person per year. The deductible does not apply. Refer wellness services for more information.</td></tr>
<tr><td>Speech therapy</td><td colspan="2">(b)(4)% of reasonable and customary after deductible up to annual maximum. Subject to (b)(4) visit limit per year that applies to all types of eligible therapy (combined limit).</td></tr>
<tr><td>Substance abuse</td><td colspan="2">Not covered.</td></tr>
<tr><td>Surgery<br>(Additional $10,000 inpatient benefit paid only if enrolled in Day One Plus)</td><td colspan="2">Surgery in a hospital is covered at (b)(4) of reasonable and customary after deductible up to annual maximum of (b)(4) (Day One Basic) or (b)(4) (Day One Plus).<br>Outpatient surgery is d at (b)(4)% of reasona ustomary after deductible up to annual maximum of (b)(4)<br>Anesthesiologist serv e covered at (b)(4) of reasonable and customary after deductible up to annual maximum.<br>Assistant surgeon services are covered at (b)(4) of reasonable and customary after deductible up to annual maximum.</td></tr>
<tr><td>Urgent Care Facility</td><td colspan="2">Doctor’s visit covered at (b)(4)% of reasonable and customary after $(b)(4) co-pay, deductible does not apply.<br>All other services performed at the urgent care facility will be paid at (b)(4)% of reasonable and customary after the deductible up to the annual maximum.</td></tr>
<tr><td>Vision care</td><td colspan="2">Not covered.</td></tr>
</table>

| | |
|---|---|
| Wellness Services | Routine wellness services are covered under this plan, up to the $(b)(4) annual plan maximum. The plan has a schedule that defines at what ages and under what circumstances routine services are recommended and covered (see wellness benefit section later in this document). Services not provided under this schedule are not covered. Highlights of covered services include:<br>• Child and adult routine physicals, including required school physicals - (b)(4)% of reasonable and customary after $(b)(4) co-pay.<br>• Recommended immunizations for children and adults – (b)(4)% of reasonable and customary, no deductible<br>• Gender- and age-based testing, such as mammograms, pap smears, PSA tests, etc. - (b)(4)% of reasonable and customary, no deductible. |
| X-rays | (b)(4)% of reasonable and customary after deductible up to annual maximum. |

* NOTE: The above chart of covered services is not an all-inclusive list. You should contact the Total Rewards Service Center or UMR if you have a question about a covered service. Certain maximums, caps and/or exclusions are placed on benefits.

*Deductible*

The deductible is the amount you have to pay before the Plan pays any benefits. The following expenses cannot be used to satisfy the $(b)(4) per person annual deductible:

- Office visit and urgent care facility co-pays
- Prescription drug co-pays
- Emergency room deductibles
- Hospital deductibles
- Wellness visits and tests
- Charges that exceed individual benefit maximums
- Charges above reasonable and customary
- Plan penalties
- Expenses for services that are not clinically appropriate or are not covered by the Plan

A co-pay applies to some services. A co-pay is a flat dollar amount (such as $(b)(4) for a doctor office visit) that does not count towards your deductible. You pay co-insurance for some expenses. Co-insurance is a percentage of total cost (such as (b)(4)% for a generic prescription drug) that does not count towards your deductible.

*Wellness Benefit*

To help you and your family live a healthy li he Plan provides a wellness benefit for certain preventive services and immunizations. The plan pays (b)(4)% of reasonable and customary expenses for qualifying preventive examinations after a $(b)(4) co-pay, and (b)(4)% of reasonable and customary expenses for immunizations and screenings, up to the $(b)(4) per-person annual limit. You will not have to meet the deductible to have this wellness benefit apply. Covered services include routine adult physicals, well baby and child exams, mammograms, pap smears, prostate specific antigen test (PSA), and immunizations. Please refer to the chart below for covered services and applicable restrictions and limitations.

**Wellness Schedule**

| Covered Service | Gender | Age(s) | Comments |
|---|---|---|---|
| Initial (new patient) comprehensive evaluation, including age and gender appropriate history, examination and ordering of appropriate lab/diagnostic procedures and/or immunizations | Both | All | |
| Annual well person examination, including vital signs, height/weight/BMI, review of family and personal heath risks, screening of vision and hearing status, growth and development milestones as appropriate | Both | All | Well child exams will be covered more frequently than annually, as age appropriate. |
| **Screenings** | | | |
| Prostate Cancer Screening: PSA, annually | Men | 50 and Older | At any age if risk factors present |
| Cervical Cancer Screening: Pap Smear at least every three years | Women | 19 to 64 | Annual screening allowed |
| Breast Cancer Screening: Mammogram every year. | Women | 40 and Older | Earlier if risk factors present; men may have screening if directed by doctor due to risk |
| Colorectal Cancer Screening:<br>• Colonoscopy every 10 years ***OR***<br>• Sigmoidoscopy every 5 years ***OR***<br>• Fecal occult blood annually ***OR***<br>• Barium enema every 5 years | Both | 50 and Older | At any age if risk factors present |
| Chlamydia Screening: | Women | Age 25 and Under | |
| Osteoporosis Screening: Once per lifetime | Both | Age 65 and Older | Post menopausal women and men over 50 if risk factors are present; if detected, BMD screenings |
| AAA by Ultrasound Screening: Once per lifetime | Men | Age 65 - 75 | Men who have smoked |
| Cholesterol/Lipid Disorders Screening: Every 5 years | Both | Age 20 and Older | More often should be considered diagnostic |
| Diabetes Screening: Every 3 Years | Both | Age 45 and Older | At any age for adults with Hyperlipidemia/Hypertension |

| Day One & PPO Immunization Schedule | | |
|---|---|---|
| **Vaccine** | **Immunization Frequency*** | **Notes** |
| Diptheria, Tetanus, Pertussis | One dose at 2 months<br>One dose at 4 months<br>One dose at 6 months<br>One booster dose between 15 and 18 months<br>One dose between ages 4 and 6<br>One dose between ages 11 and 12 | Covered between ages 13 - 18 if needed for catch-up<br>Covered as an adult in 1 dose Td booster every 10 years (substitute Tdap if less than 65 and have not previously received a dose of Tdap) |
| Haemophilus Influenza Type B | One dose at 2 months<br>One dose at 4 months<br>One dose at 6 months<br>One dose between 12 and 15 months | |
| Hepatitis A | Two doses between 12 and 23 months | Covered (HepA series) between ages 2 and 18 for high risk groups<br>Covered as an adult in 2 doses, separated by 6 - 12 months or by 1 - 18 months, if recommended** |
| Hepatitis B | One dose at birth<br>One dose between 1 and 2 months<br>One dose between 6 and 18 months | Covered between ages 7 -18 if needed for catch-up<br>Covered as an adult in 3 doses, separated by 1 - 2 months and by 4 - 6 months, if recommended** |
| Human Papillomavirus | Three doses between ages 11 and 12 (females only)<br>Three doses between ages 19 and 26 (females only) | Covered between ages 13 and 18 if needed for catch-up |
| Influenza | One dose annually between ages 6 months and 3 years<br>One dose annually after age 50 | Covered one dose annually between ages 7 - 18 for high risk groups<br>Covered one dose annually between ages 19 and 49, if recommended** |
| Measles, Mumps, Rubella | One dose between 12 and 15 months<br>One dose between ages 4 and 6<br>One or two doses between ages 19 and 49 | Covered between ages 7 -18 if needed for catch-up<br>Covered 1 dose after age 50, if recommended** |
| Meningococcal | MCV4 between ages 11 and 12 | Covered between ages 2 and 10 for high risk groups<br>Covered between ages 13 and 18 if needed for catch-up<br>Covered as an adult in one or more doses, if recommended** |
| Pneumococcal | One dose at 2 months<br>One dose at 4 months<br>One dose at 6 months<br>One dose between 12 and 18 months<br>One dose at age 65 or greater | Covered (PPV) between ages 2 and 18 for high risk groups<br>Covered (Polysaccharide) as adult in 1 - 2 doses, if recommended** |
| Polio (inactivated virus) | One dose at 2 months<br>One dose at 4 months<br>One dose between 6 and 18 months<br>One dose between ages 4 and 6 | Covered between ages 7 -18 if needed for catch-up |
| Rotavirus | One dose at 2 months<br>One dose at 4 months<br>One dose at 6 months | Covered between ages 7 - 18 if needed for catch-up |
| Varicella | One dose between 12 and 15 months<br>One dose between ages 4 and 6<br>Two doses, separated by 4 to 8 weeks, after age 50 | Covered between ages 7 - 18 if needed for catch-up |
| Zoster | One dose age 60 and greater | |

*For persons who meet the age requirements and who lack evidence of immunity

**Recommended if some other risk factor is present (medical, occupational, lifestyle or other indicators)

The Plan covers a wide range of medical services. However, certain services are not covered. Eligible medical expenses for covered services, subject to certain exclusions and limitations, include, but are not limited to, the following:

- The diagnosis or treatment of a sickness, illness, injury, or symptoms that result from a physical condition.
- Clinically appropriate services.
- Charges that do not exceed the reasonable and customary for the area.
- Charges for clinically appropriate services that meet professionally accepted, national standards of practice or quality and that are consistent with the conclusions of prevailing medical research.
- Charges for services or supplies that are not experimental, investigational, or unproven.

**Hospital Services**

Generally, the following hospital services expenses are covered under the Plan:

- Semiprivate room and board charges, and intensive care, cardiac care, and newborn care.
- Outpatient preadmission x-ray or laboratory testing.
- Operating room, recovery room, intravenous feedings, x-rays, laboratory tests, blood-transfusion services, prescription drugs and other eligible services provided during a hospital stay or in the Outpatient Department of a hospital.
- Pregnancy-related medical expenses for you or an enrolled dependent in connection with childbirth or miscarriage.

*Maternity Stay Benefits*

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if app.). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if app.).

*Surgical Services*

Generally, the following rules apply to surgical services expenses covered under the Plan:

- Assistant surgeon - Assistant surgeon's fees are covered if required by standard protocol. However, the fee is limited to no more than 20% of the fee approved for the primary surgeon. No assistant's fee is payable if the facility generally makes a qualified employee available for that purpose.
- Multiple surgical procedures - When more than one surgical procedure is performed during a single operating session, the eligible expense for the secondary procedures will be reduced.
- Repair of multiple traumatic injuries - When more than one injury is repaired during a single operating session, the eligible expense for the secondary procedures on the same bodily area or bodily system will be reduced.
- Cosmetic surgery – Cosmetic surgery that is necessary for the repair of an accidental injury.
- Dental services - Dental services or oral surgery that is provided by a dental provider or oral surgeon for the excision of a malignant tumor or when necessitated by an accidental injury is covered, provided such services are rendered with 12 months of the accident.
- Organ/Tissue transplants – covered as any other medical service.
- Reconstructive breast surgery - Reconstructive breast surgery is covered if performed in connection with a medically-necessary mastectomy (See the notice below concerning your rights under The Women's Health and Cancer Rights Act of 1998).

*Coverage for Reconstructive Surgery Following a Mastectomy*

The Women's Health and Cancer Rights Act of 1998 includes important protections for individuals who elect breast reconstruction in connection with a medically-necessary mastectomy. Under the terms of this federal act, coverage includes:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

This coverage is subject to the same deductible, coinsurance, and maximum limit provisions applicable to other medical benefits provided under the Plan.

**Emergency Services**

A medical emergency is any illness or injury that without immediate medical attention could reasonably be expected to place your life in jeopardy or could result in serious harm to bodily functions. For example, these situations are considered medical emergencies:

- Apparent heart attack
- Stroke
- Severe bleeding
- Obvious fractures

Colds, flu, nausea, sprains, earaches, and skin infections generally are not considered to be emergencies for the purpose of the Plan.

*Ambulance Transportation*

When you have an emergency, expenses for emergency transportation by an ambulance service are covered. The transportation must be from the place where you became ill or were injured to the nearest facility that can provide the necessary care.

**Exclusions**

The following are examples of the types of medical expenses which are excluded from covered charges under the Plan:

- Acupuncture - charges incurred for services or procedures involving acupuncture for any reason other than pain relief.
- Air Purification - charges for air conditioners, air-purification units, humidifiers, electric heating units and similar devices.
- Biofeedback - charges for biofeedback, recreational or educational therapy, or any other form of self-care or self-help training, or any related diagnostic testing.
- Birth Control - charges for contraceptive drugs, medicines, or devices used to prevent pregnancy, except as specifically indicated by the Plan.
- Blood - whole blood or plasma when donated or otherwise replaced by or on behalf of the patient.
- Charges Exceeding Reasonable and Customary - charges that are in excess of reasonable and customary allowance for the service provided. Reasonable and Customary means those charges made by eligible facilities and providers for services which do not exceed the general level of charges for the same services in the geographical region where the services are furnished.

- Charges Not A Covered Health Service - charges that are not a Covered Health Service. A Covered Health Service is a health service or supply that is provided for the purpose of preventing, diagnosing or treating an illness or injury and: is supported by national medical standards of practice; is consistent with conclusions of prevailing medical research that the service or supply has a beneficial effect on health outcomes; and is the most cost-effective method and yields a similar outcome to other available alternatives.
- Chelation Therapy - charges for chelation therapy, except for the treatment of heavy metal poisoning.
- Childhood Disorders - treatment of learning disorders, developmental delay, behavioral problems, mental retardation, or autism of childhood.
- Cosmetic Services - any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when: (a) necessitated by a non-occupational accidental injury; or (b) necessary to correct a condition, including a birth defect, which impairs the function of a body organ.
- Court Ordered Care – charges for care, confinement or treatment in a public or private institution as the result of a court order.
- Coverage Not in Effect - charges for services or supplies provided before your effective date of coverage under the Plan, or provided after your termination of coverage under the Plan.
- Custodial Care - charges for custodial care, including institutions that are custodial in nature such as homes for the aged, rest homes, and schools for the mentally retarded.
- Dental Procedures - charges for dental care or treatment, except for the excision of malignant tumors, and treatment by a physician, dentist or dental surgeon for accidental injury to natural teeth, as specifically indicated by the Plan.
- Diagnostic Hospital Admissions - confinement in a hospital for diagnostic purposes only, when such diagnostics could be performed in an outpatient setting.
- Ecological or Environmental Medicine - chelation or chelation therapy, orthomolecular substances, use of substances of animal, vegetable, chemical or mineral origin which are not specifically approved by the FDA as effective for treatment.
- Education or Training - charges for education or training of any kind, or to assist an individual in pursuing a trade or occupation. Charges for diabetic counseling by a registered dietician, physician or other covered provider are covered under the Plan.
- Employer's Medical Clinic - charges for services provided in a medical department or clinic maintained by the Company.
- Excess Prescriptions – charges for any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one (1) year from the physician's original order.
- Exercise Equipment and Health Clubs - exercising equipment, vibratory equipment, swimming or therapy pools, or enrollment in health, athletic or similar clubs.
- Experimental, Investigational or Unproven Services - charges for treatments, procedures, devices or drugs which the Plan Administrator determines, in the exercise of its discretion, are experimental, investigational or unproven services.
- Felony Participation - charges for an illness or injury sustained during the commission, or attempted commission, of an assault or felony, or injuries sustained while engaging in an illegal occupation, except that this exclusion does not apply to illness or injury sustained due to a medical condition or domestic violence.
- Genetic Counseling or Testing - counseling or testing for inherited (genetic) disorders.
- Hair Replacement - replacement of nonproductive hair follicles with productive follicles from another area of the scalp or body, for treatment of alopecia (baldness), or any other treatments, drugs, or supplies for baldness, except as specifically indicated in the Plan.
- Hearing Aids – charges for hearing aids and examinations for them.
- Holistic or Homeopathic Medicine - services, supplies or accommodations provided in connection with holistic or homeopathic treatment, including drugs.
- Hypnotherapy - treatment by hypnosis.

- Impregnation - services and supplies for or related to artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.
- Legal Prohibition - charges prohibited by any law of the jurisdiction in which you reside at the time the expense is incurred.
- Licensed Physician - charges for a physician or other provider acting outside the scope of the physician's or other provider's license.
- Maintenance Treatment - charges for services that do not seek to cure, or are provided during periods when the medical condition of the patient is not changing, or do not require continued administration by medical personnel.
- Marriage and Family Counseling - counseling to resolve family or marital difficulties.
- Mileage Costs and Claim Forms - charges for mileage costs, completion of claim forms, or preparation of medical reports.
- Military Service - charges for treatment of any sickness or injury incurred while in the military, naval or air service of any country.
- Nicotine Addiction - nicotine withdrawal programs, facilities and drugs or supplies, except as specifically indicated in the Plan.
- No-Charge Services - charges for which the service was furnished without charge or would have been furnished without charge if this Plan were not in effect.
- Non-Prescription Drugs - drugs which can be purchased over the counter and without a physician's written prescription (except for insulin, diabetic supplies, and syringes or the administration of insulin) and drugs for which there is a non-prescription equivalent available.
- Obesity and Weight Loss - charges for treatment for obesity, including diet control and weight reduction, when not required by a specifically identified condition of morbid obesity and disease etiology.
- Orthopedic Shoes - charges for orthopedic shoes (unless the shoes are permanently attached to braces), and other supportive appliances for the feet (except that orthotics are covered).
- Other Plan Provisions - charges under one coverage of this Plan to the extent that benefits are payable for the same charges under another coverage provided under this Plan.
- Personal Comfort or Convenience Items - charges for services or supplies provided for personal comfort and not necessary for the treatment of covered sickness, accidental injury or pregnancy, including, but not limited to, the purchase or rental of telephones, televisions, orthopedic mattresses, allergy-free pillows, blankets and/or mattress covers, non-hospital adjustable beds, waterbeds, motorized transportation equipment, elevators, escalators, professional medical equipment (such as blood pressure kits), or supplies or attachments to such equipment.
- Physician Approval - charges for any treatment not recommended or approved by a physician.
- Prescription Drugs - prescription drugs not specifically available under the prescription drug benefits portion of the Plan and the following excluded drugs and devices: non-federal legend drugs; fertility medications; insulin devices; contraceptive implants and devices; Minoxidil/Rogaine (and any other drug whose sole purpose is to promote hair growth); Retin A (only allowed through age 19); nutritional supplements; prescription vitamins (except prenatal); AIDS-related tests; steroids for body building; Relenza; Tamiflu; allergy sera; immunization agents and vaccines; biologicals, blood and blood plasma; experimental drugs; investigational drugs; unproven drugs; medical devices; over-the-counter drugs (except that benefits are available for over-the-counter diabetic supplies).
- Prosthetic Replacements - replacement of prosthetic devices, unless necessitated because of wear or bodily change.
- Public Programs - charges made for services or supplies which can be paid for by any government agency, even if you waive rights to those services or supplies.
- Radial Keratotomy - charges incurred for services or procedures involving radial keratotomy, refractive keratoplasty, LASIK, or similar procedures.
- Routine Foot Care - charges for non-surgical treatment of the feet, including treatment of corns, calluses, toenails or other routine foot care, unless the charges are for removal of nail roots or for the treatment of a metabolic or peripheral-vascular disease.

- Routine or Preventive Care - charges for examinations and procedures performed for screening, survey, or research, or for pre-marital examinations, camp, or employment purposes, or for routine examinations or check-ups or immunizations, except as specifically indicated in the Plan.
- Sales Tax – charges for sales tax or other tax imposed by law.
- Self-Procured Services - services rendered if you are not under the regular care of a physician and for services, supplies or treatment, including any period of hospitalization, which are not recommended, approved and certified as necessary and reasonable by a physician.
- Services of an Immediate Relative - charges for services which are self-administered or rendered by an immediate relative.
- Sex Change Procedures, Services or Supplies - sex change counseling, or treatment or services or supplies incident to sex change surgery or any resulting complications.
- Sex Counseling or Treatment - treatment, therapy or counseling for sexual dysfunctions or inadequacies not related to organic disease.
- Sleep Disorders - charges for sleep disorders, unless there is documented evidence of sleep apnea.
- Speech Therapy - charges for speech therapy to correct a non-organic speech defect.
- Sterilization Reversal - charges in connection with surgery to reverse voluntary sterilization.
- Technical Medical Assistance - charges for technical medical assistance or standby physician services.
- Telephone Consultations - charges for telephone consultations.
- Temporomandibular Joint Dysfunction - nonmedical treatment of TMJ.
- Travel Expenses - charges for travel expenses, whether or not recommended by a physician, except as specifically provided under the organ/tissue transplant benefit.
- Treatment Not Provided by a Physician - charges for treatment not provided by a physician or other covered provider.
- Treatment Outside the U.S. - charges incurred outside of the United States if you travel to such a location for the primary purpose of obtaining such services, drugs or supplies.
- U.S. Government Hospitals - charges for services or supplies provided by the Veterans Administration or in any hospital or institution owned, operated, or maintained by the United States government for a service-related sickness or injury.
- Unnecessary Hospital Treatment - charges for hospital services not consistent with and not required in the management and treatment of a sickness or injury for which you are admitted.
- Vision Expenses - charges for eyeglasses or contact lenses, except as necessary following cataract surgery, and examinations for their prescription or fitting, orthoptic, vision therapy or other special vision procedures.
- Vitamins and Nutritional Supplements – charges for nutritional supplements, unless the patient's sole nutrition (liquid or medication) is by gastrostomy/NG tube feeding and such supplements are deemed as covered by the Plan; or charges for vitamins, even if a written prescription is provided, except that prescription pre-natal vitamins are covered.
- Vocational Testing or Training - vocational testing, evaluation, counseling or training.
- War-Related Expenses - charges for treatment of any illness or injury caused by war, act of war, riot, civil disobedience, nuclear explosion, nuclear accidents, or similar event whether such event be declared or undeclared war, except that this exclusion does not apply to illness or injury sustained due to a medical condition or domestic violence.
- Wigs or Wig Maintenance – purchase of more than one synthetic wig or its equivalent, for hair loss due to sickness or medical treatment (such as chemotherapy); or the repair, replacement or maintenance (cleaning, etc.) of a wig.
- Work-Related Conditions - any condition which arises from or is sustained in the course of any occupation or employment for compensation, or any condition for which coverage is available, in whole or in part, under any Workers' Compensation Act or similar legislation.

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**From:** Botwinick, Alexandra (HHS/OCIIO)
**Sent:** Thursday, October 21, 2010 11:55 AM
**To:** 'Lwalker@darden.com'
**Subject:** Incomplete Waiver Application

**Importance:** High

Ms Walker,

I am in the process of reviewing the waiver application for Darden Restaurants. In order to complete my review I need the following information.

1. The projected monthly premium if the plan was denied the waiver
2. The percent increase between the current premium and the projected premium if the plan was denied the waiver
3. Is the plan self insured or fully insured

Once I have the above information I can continue my review. Thank you for your attention to this matter.

Sincerely,

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
alexandra.botwinick@hhs.gov

From: Lynda Walker [LWalker@darden.com]
Sent: Friday, October 22, 2010 10:24 AM
To: Botwinick, Alexandra (HHS/OCIIO)
Subject: RE: Incomplete Waiver Application

Dear Ms. Botwinick,

Thank you for your consideration of our waiver.

The projected monthly premium if the plan is denied the waiver and the percent increase between the current premium and the projected premium if the plan was denied the waiver are shown below:

| Day One | n is denied waiver | % Increase (if plan is denied) |
|---|---|---|
| Employee only | (b)(4) | |
| Employ | | |
| Family | (b)(4) | |

The plan is self insured.

Again, thank you for your time and effort on our behalf.

Best regards,

Lynda Walker

_____

From: Botwinick, Alexandra (HHS/OCIIO) [Alexandra.Botwinick@hhs.gov]
Sent: Thursday, October 21, 2010 11:55 AM
To: Lynda Walker
Subject: Incomplete Waiver Application

Ms Walker,

I am in the process of reviewing the waiver application for Darden Restaurants. In order to complete my review I need the following information.

1. The projected monthly premium if the plan was denied the waiver 2. The percent increase between the current premium and the projected premium if the plan was denied the waiver 3. Is the plan self insured or fully insured

Once I have the above information I can continue my review. Thank you for your attention to this matter.

Sincerely,

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
alexandra.botwinick@hhs.gov<mailto:alexandra.botwinick@hhs.gov>

10/4 Dup

DARDEN

Red Lobster ▪ Olive Garden ▪ LongHorn Steakhouse ▪ The Capital Grille ▪ Bahama Breeze ▪ Seasons 52

September 28, 2010

Mr. James Mayhew
Department of Health and Human Services,
Office of Consumer Information and Insurance Oversight
Room 737-F-04
200 Independence Avenue, SW
Washington, DC 20201

Re: Waiver Application – Darden

Dear Mr. Mayhew:

Thank you in advance for your consideration of our Waiver Application for Darden's limited benefit plan, which we refer to as our Day 1 plan. A copy of our Waiver Application also was sent to your office via e-mail.

We have enclosed both the signed Waiver Application and the summary plan description for the plan, which is entitled "Summary Plan Description for Day One Medical and Prescription Drug Benefits Under the Darden Restaurants Group Life and Health Plan for Store Staff Employees.

Our Day 1 plan enables us to provide an affordable level of immediate (no waiting period) access to coverage to the vast majority of Darden's employees and their dependents. These Limited Medical Plans provide an affordable option for access to first dollar medical and pharmacy coverage. Removing Darden's ability to utilize a Limited Medical Plan strategy would eliminate this highly-appreciated, highly-valued, and affordable benefit from (b)(4) employees and dependents enrolled and (b)(4) others with the option to enroll today.

Please contact me by telephone (407-245-6118) or e-mail (lwalker@darden.com) if you have any questions or need any additional information.

Thank you again for your consideration of our waiver application.

Best regards,

Lynda Walker

Lynda Walker
Vice President, Total Rewards Design

# Annual Dollar Limit Waiver Application for Self Insured Options

| | |
|---|---|
| **Employer Name** Darden Restaurants, Inc. | **EIN** 59-3305930 |

**Employer Address** 1000 Darden Center Drive, Orlando, FL 32837 (phone: 407.245.4000)

**Plan Option Name** Two Options: Day One Basic Plan and Day One Plus Plan

**Number of individuals covered (employees and dependents)**

Day One Basic Plan–Varies between (b)(4) employees and additional (b)(4) dependents

Day One Plus Plan– Varies between (b)(4) employees and additional (b)(4) dependents

**Summary Plan Description (SPD)**
The SPD, "Summary Plan Description for Day One Medical and Prescription Drug Benefits Under the Darden Restaurants Group Life and Health Plan for Store Staff Employees", is attached to the waiver application.

| **Annual Limit Amount** | **Rate Amount** |
|---|---|
| Day One Basic Plan–Plan pays (b)(4)% of Reasonable and Customary up to $ (b)(4) annually; Up to an additional $ (b)(4) for Wellness and $ (b)(4) for Prescriptions<br><br>Day One Plus Plan–Plan pays (b)(4)% of Reasonable and Customary up to $ (b)(4) annual maximum for in-patient stay ($ (b)(4) maximum on other covered services); Up to an additional $ (b)(4) for Wellness and $ (b)(4) for Prescriptions | Weekly rates are shown below (assuming 52 weeks a year):<br><br>Format–Employee Only/Employee+One/Family<br>Day One Basic Plan–<br>Day One Plus Plan–$ (b)(4)<br><br>All rates are for 2011 and the rate frequency is weekly (again, assuming 52 weeks a year). |

**Brief Description of why compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans, or significant increase in premiums paid by those covered by such plans, along with any supporting documentation.**

In order to provide an affordable level of immediate (no waiting period) access to coverage to the vast majority of Darden's employees and their dependents, Darden has employed a Limited Medical Plan strategy dating back prior to 1997. These Limited Medical Plans provide an affordable option for access to first dollar medical and pharmacy coverage.

Removing Darden's ability to utilize a Limited Medical Plan strategy would eliminate this highly-appreciated, highly-valued, and affordable benefit from (b)(4) employees and dependents enrolled and (b)(4) others with the option to enroll today. To remove the Annual Maximums and move the population to a more traditional PPO option would result in employee's cost of coverage being four to five times higher than what is required under the 2011 Limited Medical Plans Strategy.

Danielle L Kuyon — 9/28/10

**Plan Administrator Signature** — **Date**

Attestation certifying (1) that the plan was in force prior to September 23, 2010; and (2) that the application of restricted annual limits would result in a significant decrease in access to benefits for those currently covered by the plan, or a significant increase in premiums paid by those covered by such plans or policies.

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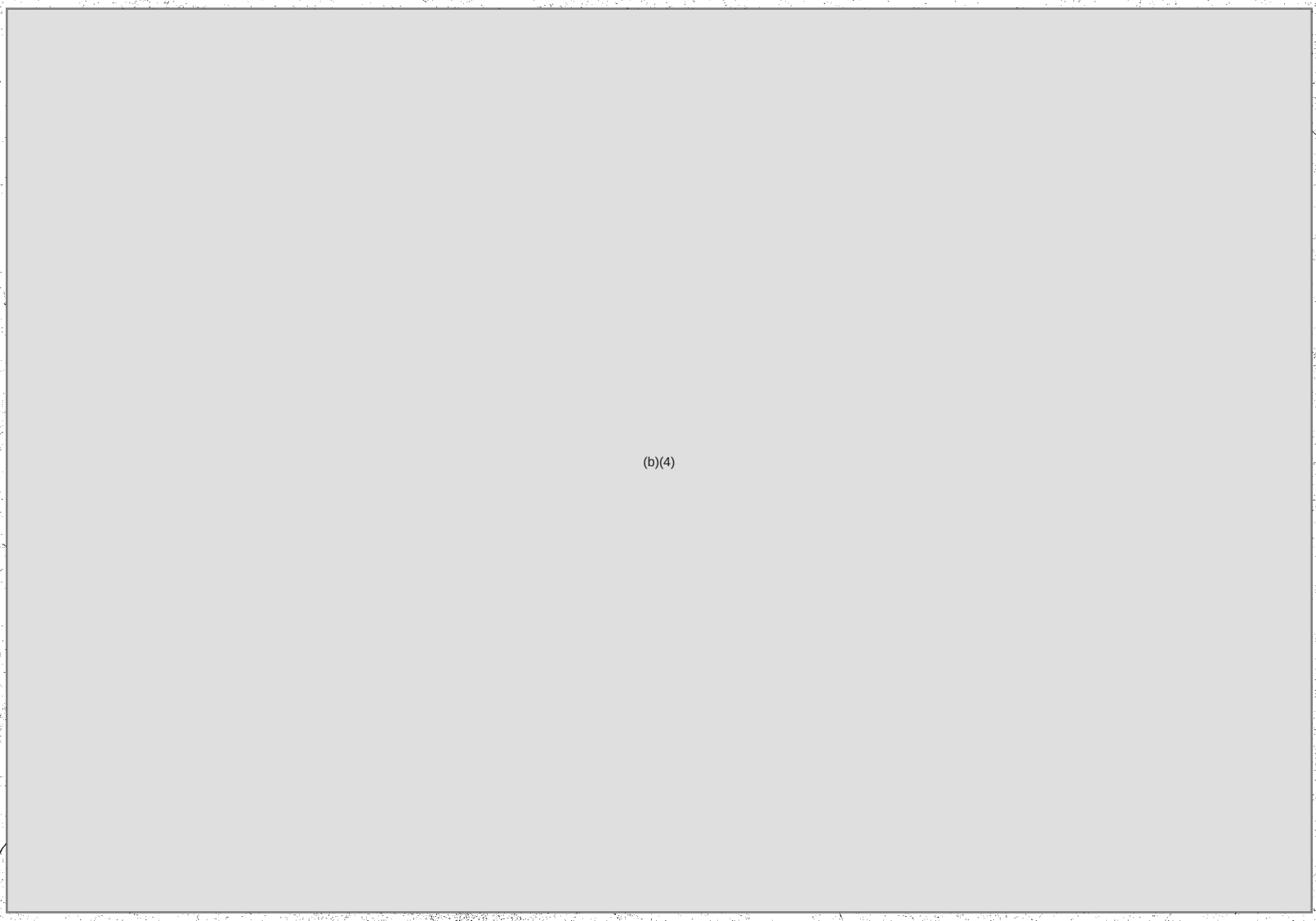


## SUMMARY OF DAY ONE BENEFITS

### Day One Basic Option

The Day One Basic option has a (b)(4) per-person deductible and a (b)(4) per-person annual Plan limit that can be used for any covered medical service, including hospitalization. Wellness coverage has a separate and additional (b)(4) per-person annual limit. The Day One Basic option requires you pay a modest deductible and low fees for doctor office visits for you and your enrolled dependents. Once the Plan has paid (b)(4) on your behalf for medical expenses and (b)(4) for wellness expenses in a Plan Year, no more coverage for medical or wellness expenses will be provided for the remainder of the Plan Year. The Day One Basic option also includes a (b)(4) annual prescription benefit for each covered individual. With this coverage, you (i) pay a (b)(4)% co-insurance or minimum co-pays for prescriptions; (ii) can use mail order service for long-term maintenance medications to reduce costs; and (iii) can continue to access prescription network discounts after the annual (b)(4) prescription benefit has been used, which may help lower your costs. This plan does not require prior notification for any services.

### Day One Plus Option

The Day One Plus option provides the same basic coverage as the Day One Basic option (up to (b)(4) for medical and (b)(4) for wellness each Plan Year,) and provides an additional (b)(4) annual benefit for in-patient hospitalization only (this additional (b)(4) amount cannot be used for out-patient services.) This Day One Plus option has an annual hospitalization deductible of (b)(4) that applies each time you or a

dependent are hospitalized, and is in addition to the annual (b)(4) per-person deductible. The Day One Plus option similarly includes a (b)(4) annual prescription benefit for each covered individual. With this coverage, you (i) pay a (b)(4)% co-insurance or minimum co-pays for prescriptions; (ii) can use mail order service for long-term maintenance medications to reduce costs; and (iii) can continue to access prescription network discounts after the annual $(b)(4) prescription benefit has been used, which may help lower your costs. This plan does not require prior notification for any services.

## Day One Basic & Day One Plus Plan Differences

In most cases, benefits in the Day One Basic and Day One Plus options are the same – $(b)(4) deductible, office visits, prescription drugs, wellness schedules, laboratory fees, maternity, etc. However, there are also key differences as outlined:

| | Day One Basic | Day One Plus |
|---|---|---|
| **Maximum benefit** | Plan pays (b)(4) annually. Prescriptions and wellness excluded from annual maximum; see covered services above. | Plan pays (b)(4) annual maximum for hospital stay (includes the (b)(4) Basic maximum available for other covered services, excluding prescriptions and wellness). |
| **Hospital Admission Deductible** | (b)(4) | |
| **Inpatient Hospital Care (including maternity)** | You pay (b)(4)% of eligible charges after deductible ($ (b)(4) maximum). | You pay (b)(4)% of eligible charges after deductible ($ (b)(4) maximum, $ (b)(4) if Basic maximum has been exhausted). |
| **Emergency Care** | You pay (b)(4)% of eligible charges after annual deductible and separate $(b)(4) Emergency Room deductible. | You pay (b)(4)% of eligible charges after annual deductible and separate $(b)(4) Emergency Room deductible.<br><br>$(b)(4) Emergency Room deductible is waived if admitted; then inpatient hospital admission deductible applies. |

## Covered Medical Services

The following chart of covered services provides highlights of the Day One Basic and Day One Plus medical benefits available under the Plan. **This plan does not require prior notification for any services.**

| Benefit | Coverage |
|---|---|
| Allergy tests | (b)(4)% of reasonable and customary after deductible up to annual maximum. |
| Allergy treatment | (b)(4)% of reasonable and customary after deductible up to annual maximum. |
| Alternative medicine | Not covered. |
| Ambulance charges | (b)(4)% of reasonable and customary after deductible up to annual maximum. |
| Birth control pills | Covered like any other prescription drug. |
| CAT scans | (b)(4)% of reasonable and customary after deductible up to annual maximum. |
| Chiropractors | (b)(4)% of reasonable and customary after deductible up to $ (b)(4) in a calendar year. |

| Benefit | Coverage |
|---|---|
| Cosmetic surgery | Covered like any other surgery only if the result of:<br>• A medically-necessary mastectomy.<br>• A non-occupational accidental injury, or to correct a condition, including a birth defect, which impairs bodily function.<br>In compliance with Title IX, Women's Health and Cancer Rights, added to ERISA by the 1998 Omnibus Budget Bill, the following services complementing medical and surgical benefits for mastectomies, in a manner determined in consultation with the attending physician and the patient:<br>a) Reconstruction of the breast on which the mastectomy was performed;<br>b) Surgery or reconstruction of the other breast to produce a symmetrical appearance; and<br>c) Prostheses and physical complications with all states of the mastectomy, including lymph edemas.<br>All relevant Plan Provisions regarding annual deductibles, coinsurance, and copayments apply to these additional services. |
| Dental treatment | Covered only if treatment is for the excision of a malignant tumor or if required to repair or replace sound natural teeth damaged in an accident. Covers hospitalization if clinically appropriate. |
| Durable medical equipment | (b)(4)% of reasonable and customary after deductible up to annual maximum. |
| Emergency care | (b)(4)% of reasonable and customary after the annual deductible of $(b)(4) and a separate and additional $(b)(4) Emergency Room deductible up to the annual plan maximum. Emergency Room deductible will be waived upon admission. |
| Gynecology visits | (b)(4)% of reasonable and customary after $(b)(4) co-pay up to $(b)(4) maximum, if qualified under the plan's wellness schedule. Deductible does not apply. Gynecological visits for treatment of a medical condition are covered like any other doctor office visit and not subject to the wellness schedule. |
| Hearing care | Not covered. |
| Home health care | (b)(4)% of reasonable and customary up to annual maximum. Deductible does not apply. Maximum of (b)(4) per visit up to (b)(4) visits per calendar year. |
| Hospice care | (b)(4)% of reasonable and customary. Deductible does not apply. Limit $(b)(4) per day. Maximum $ (b)(4) per year for inpatient care, $ (b)(4) per year for home care. |
| Hospital Outpatient Department or Ambulatory Surgical Facility | (b)(4)% of reasonable and customary up to annual plan maximum of $ (b)(4)<br>Eligible wellness services in a Hospital Outpatient Department or Ambulatory Surgical Facility would be paid at (b)(4)% of reasonable and customary up to the annual Wellness benefit of $(b)(4) |
| Hospital stay<br>(Additional $10,000 inpatient benefit paid only if enrolled in Day One Plus) | (b)(4)% of reasonable and customary after applicable deductibles up to annual maximum. Inpatient hospital benefits are subject to annual plan maximum benefit of $ (b)(4) (Day One Basic) or $ (b)(4) (Day One Plus).<br>Covers the cost of a semiprivate room. Private rooms are covered up to the semiprivate room rate unless:<br>A private room is clinically appropriate<br>The hospital has only private rooms<br>Doctor visits during hospitalization are covered at (b)(4)% of reasonable and customary after deductible up to the annual maximum. |
| Immunizations | Per wellness schedule, covered at (b)(4)% to maximum of $(b)(4) per person per year. The deductible does not apply. Refer to wellness services for more information. |

| Benefit | Coverage |
|---|---|
| Infertility treatment | Not covered. |
| Laboratory charges | (b)(4)% of reasonable and customary after deductible up to annual maximum. |
| Magnetic Resonance Imaging - MRI | (b)(4)% of reasonable and customary after deductible up to annual maximum. |
| Mammograms | Per wellness schedule, covered at (b)(4)% to maximum of $(b)(4) per person per year. The deductible does not apply. Refer to wellness services for more information. |
| Mental health | Not covered. |
| Occupational therapy | (b)(4)% of reasonable and customary after deductible up to annual maximum. Subject to (b)(4) visit limit per year that applies to all types of eligible therapy (combined limit). |
| Office visits | (b)(4)% of reasonable and customary after $(b)(4) co-pay up to annual maximum. Deductible does not apply. |
| Organ transplant | (b)(4)% of reasonable and customary after deductible up to annual maximum. |
| Pap smears | Per wellness schedule, covered at (b)(4)% to maximum of $(b)(4) per person per year. The deductible does not apply. Refer to wellness services for more information. |
| Physical exams for adults | Per wellness schedule, covered (b)(4)% of reasonable and customary after $(b)(4) co-pay to maximum of $(b)(4) per person per year. The deductible does not apply. Refer to wellness services for more information. |
| Physical exams for children | Per wellness schedule, covered (b)(4)% of reasonable and customary after $(b)(4) co-pay to maximum of $(b)(4) per person per year. The deductible does not apply. Refer to wellness services for more information. |
| Physical therapy | (b)(4)% of reasonable and customary after deductible up to annual maximum. Subject to (b)(4) visit limit per year that applies to all types of eligible therapy (combined limit). |
| Pregnancy / Maternity<br>(Additional $ (b)(4) inpatient benefit paid only if enrolled in Day One Plus) | Doctor delivery charges covered (b)(4)% of reasonable and customary after deductible up to annual maximum of $ (b)(4) (Day One Basic) or (b)(4) (Day One Plus.) Routine prenatal visits and labs are included in the delivery charge.<br>Maternity hospital stay covered at (b)(4)% of reasonable and customary after applicable deductibles up to annual maximum.<br>Newborn nursery charges covered at (b)(4)% of reasonable and customary after deductible up to annual maximum of $ (b)(4) (Day One Basic) or $ (b)(4) (Day One Plus.) Also covered is the initial pediatric exam at (b)(4)% of reasonable and customary, and circumcision at (b)(4)% of reasonable and customary after deductible, up to the applicable annual maximum.<br>A child is covered at birth as long as the baby meets the dependent child eligibility requirements and is added to the plan within (b)(4) days of birth.<br>Midwife services are covered at the same level as a physician. A licensed birthing center is covered at the same rate as a hospital. These services are considered outpatient and are limited to the $ (b)(4) annual maximum. |

<table>
<tr><td rowspan="7">Prescription drugs</td><td colspan="2">You are eligible for up to (b)(4) in prescription coverage (per covered person) per calendar year. Use a pharmacy in the Medco Health/Solution network for your best benefit. If you go outside the network, you pay a higher cost and have to pay up front and file a claim for reimbursement. Visit the Medco website at www.medco.com or call 1-800-875-3142.<br>Deductible does not apply. Once the plan has paid (b)(4) in prescription expenses, you will still be able to access network discounts which may help lower your cost.</td></tr>
<tr><td>Coverage</td><td>You Pay</td></tr>
<tr><td>Pharmacy Generic Network</td><td>(b)(4)% co-insurance (minimum $10 co-pay) up to 30 day supply. After the third pharmacy refill, co-insurance increases to (b)(4)% and Mail Order may be a better option.</td></tr>
<tr><td>Pharmacy Generic Out-Of-Network</td><td>(b)(4)% co-insurance (minimum $(b)(4) co-pay) plus any amount over network rate up to 30 day supply. After the third pharmacy refill, co-insurance increases to (b)(4)% and Mail Order may be a better option.</td></tr>
<tr><td>Pharmacy Brand Network</td><td>(b)(4)% co-insurance for a non-maintenance drug (minimum $(b)(4) co-pay) / (b)(4)% co-insurance for a maintenance drug (minimum $(b)(4) co-pay) up to 30 day supply.</td></tr>
<tr><td>Pharmacy Brand Out-Of-Network</td><td>(b)(4)% co-insurance for a non-maintenance drug (minimum $(b)(4) co-pay) / (b)(4)% co-insurance for a maintenance drug (minimum $(b)(4) co-pay) plus any amount over the network rate up to 30 day supply.</td></tr>
<tr><td>Mail Order Generic</td><td>(b)(4)% co-insurance (minimum $(b)(4) co-pay) up to 90 day supply. $(b)(4) maximum per prescription.</td></tr>
<tr><td>Mail Order Brand</td><td>(b)(4)% co-insurance (minimum $(b)(4) co-pay) up to 90 day supply. $(b)(4) maximum per prescription.</td></tr>
<tr><td>Prostate Specific Antigen test - PSA</td><td colspan="2">Per wellness schedule, covered at (b)(4)% to maximum of $(b)(4) per person per year. The deductible does not apply. Refer to wellness services for more information.</td></tr>
<tr><td>Speech therapy</td><td colspan="2">(b)(4)% of reasonable and customary after deductible up to annual maximum. Subject to (b)(4) visit limit per year that applies to all types of eligible therapy (combined limit).</td></tr>
<tr><td>Substance abuse</td><td colspan="2">Not covered.</td></tr>
<tr><td>Surgery<br>(Additional $10,000 inpatient benefit paid only if enrolled in Day One Plus)</td><td colspan="2">Surgery in a hospital is covered at (b)(4)% of reasonable and customary after deductible up to annual maximum of $ (b)(4) (Day One Basic) or $ (b)(4) (Day One Plus).<br>Outpatient surgery is covered at (b)(4)% of reasonable and customary after deductible up to annual maximum of $ (b)(4)<br>Anesthesiologist services are covered at (b)(4)% of reasonable and customary after deductible up to annual maximum.<br>Assistant surgeon services are covered at (b)(4)% of reasonable and customary after deductible up to annual maximum.</td></tr>
<tr><td>Urgent Care Facility</td><td colspan="2">Doctor's visit covered at (b)(4)% of reasonable and customary after $(b)(4) co-pay, deductible does not apply.<br>All other services performed at the urgent care facility will be paid at (b)(4)% of reasonable and customary after the deductible up to the annual maximum.</td></tr>
<tr><td>Vision care</td><td colspan="2">Not covered.</td></tr>
</table>

| | |
|---|---|
| Wellness Services | Routine wellness services are covered under this plan, up to the $(b)(4) annual plan maximum. The plan has a schedule that defines at what ages and under what circumstances routine services are recommended and covered (see wellness benefit section later in this document). Services not provided under this schedule are not covered. Highlights of covered services include:<br>• Child and adult routine physicals, including required school physicals - (b)(4)% of reasonable and customary after $(b)(4) co-pay.<br>• Recommended immunizations for children and adults – (b)(4)% of reasonable and customary, no deductible<br>• Gender- and age-based testing, such as mammograms, pap smears, PSA tests, etc. - (b)(4)% of reasonable and customary, no deductible. |
| X-rays | (b)(4)% of reasonable and customary after deductible up to annual maximum. |

* NOTE: The above chart of covered services is not an all-inclusive list. You should contact the Total Rewards Service Center or UMR if you have a question about a covered service. Certain maximums, caps and/or exclusions are placed on benefits.

*Deductible*

The deductible is the amount you have to pay before the Plan pays any benefits. The following expenses cannot be used to satisfy the $(b)(4) per person annual deductible:

- Office visit and urgent care facility co-pays
- Prescription drug co-pays
- Emergency room deductibles
- Hospital deductibles
- Wellness visits and tests
- Charges that exceed individual benefit maximums
- Charges above reasonable and customary
- Plan penalties
- Expenses for services that are not clinically appropriate or are not covered by the Plan

A co-pay applies to some services. A co-pay is a flat dollar amount (such as $(b)(4) for a doctor office visit) that does not count towards your deductible. You pay co-insurance for some expenses. Co-insurance is a percentage of total cost (such as (b)(4)% for a generic prescription drug) that does not count towards your deductible.

*Wellness Benefit*

To help you and your family live a healthy life, the Plan provides a wellness benefit for certain preventive services and immunizations. The plan pays (b)(4)% of reasonable and customary expenses for qualifying preventive examinations after a $(b)(4) co-pay, and (b)(4)% of reasonable and customary expenses for immunizations and screenings, up to the $(b)(4) per-person annual limit. You will not have to meet the deductible to have this wellness benefit apply. Covered services include routine adult physicals, well baby and child exams, mammograms, pap smears, prostate specific antigen test (PSA), and immunizations. Please refer to the chart below for covered services and applicable restrictions and limitations.

**Wellness Schedule**

| Covered Service | Gender | Age(s) | Comments |
|---|---|---|---|
| Initial (new patient) comprehensive evaluation, including age and gender appropriate history, examination and ordering of appropriate lab/diagnostic procedures and/or immunizations | Both | All | |
| Annual well person examination, including vital signs, height/weight/BMI, review of family and personal heath risks, screening of vision and hearing status, growth and development milestones as appropriate | Both | All | Well child exams will be covered more frequently than annually, as age appropriate. |
| **Screenings** | | | |
| Prostate Cancer Screening: PSA, annually | Men | 50 and Older | At any age if risk factors present |
| Cervical Cancer Screening: Pap Smear at least every three years | Women | 19 to 64 | Annual screening allowed |
| Breast Cancer Screening: Mammogram every year. | Women | 40 and Older | Earlier if risk factors present; men may have screening if directed by doctor due to risk |
| Colorectal Cancer Screening:<br>• Colonoscopy every 10 years ***OR***<br>• Sigmoidoscopy every 5 years ***OR***<br>• Fecal occult blood annually ***OR***<br>• Barium enema every 5 years | Both | 50 and Older | At any age if risk factors present |
| Chlamydia Screening: | Women | Age 25 and Under | |
| Osteoporosis Screening: Once per lifetime | Both | Age 65 and Older | Post menopausal women and men over 50 if risk factors are present; if detected, BMD screenings |
| AAA by Ultrasound Screening: Once per lifetime | Men | Age 65 - 75 | Men who have smoked |
| Cholesterol/Lipid Disorders Screening: Every 5 years | Both | Age 20 and Older | More often should be considered diagnostic |
| Diabetes Screening: Every 3 Years | Both | Age 45 and Older | At any age for adults with Hyperlipidemia/Hypertension |

| Day One & PPO Immunization Schedule | | |
|---|---|---|
| **Vaccine** | **Immunization Frequency*** | **Notes** |
| Diptheria, Tetanus, Pertussis | One dose at 2 months<br>One dose at 4 months<br>One dose at 6 months<br>One booster dose between 15 and 18 months<br>One dose between ages 4 and 6<br>One dose between ages 11 and 12 | Covered between ages 13 - 18 if needed for catch-up<br>Covered as an adult in 1 dose Td booster every 10 years (substitute Tdap if less than 65 and have not previously received a dose of Tdap) |
| Haemophilus Influenza Type B | One dose at 2 months<br>One dose at 4 months<br>One dose at 6 months<br>One dose between 12 and 15 months | |
| Hepatitis A | Two doses between 12 and 23 months | Covered (HepA series) between ages 2 and 18 for high risk groups<br>Covered as an adult in 2 doses, separated by 6 - 12 months or by 1 - 18 months, if recommended** |
| Hepatitis B | One dose at birth<br>One dose between 1 and 2 months<br>One dose between 6 and 18 months | Covered between ages 7 -18 if needed for catch-up<br>Covered as an adult in 3 doses, separated by 1 - 2 months and by 4 - 6 months, if recommended** |
| Human Papillomavirus | Three doses between ages 11 and 12 (females only)<br>Three doses between ages 19 and 26 (females only) | Covered between ages 13 and 18 if needed for catch-up |
| Influenza | One dose annually between ages 6 months and 3 years<br>One dose annually after age 50 | Covered one dose annually between ages 7 - 18 for high risk groups<br>Covered one dose annually between ages 19 and 49, if recommended** |
| Measles, Mumps, Rubella | One dose between 12 and 15 months<br>One dose between ages 4 and 6<br>One or two doses between ages 19 and 49 | Covered between ages 7 -18 if needed for catch-up<br>Covered 1 dose after age 50, if recommended** |
| Meningococcal | MCV4 between ages 11 and 12 | Covered between ages 2 and 10 for high risk groups<br>Covered between ages 13 and 18 if needed for catch-up<br>Covered as an adult in one or more doses, if recommended** |
| Pneumococcal | One dose at 2 months<br>One dose at 4 months<br>One dose at 6 months<br>One dose between 12 and 18 months<br>One dose at age 65 or greater | Covered (PPV) between ages 2 and 18 for high risk groups<br>Covered (Polysaccharide) as adult in 1 - 2 doses, if recommended** |
| Polio (inactivated virus) | One dose at 2 months<br>One dose at 4 months<br>One dose between 6 and 18 months<br>One dose between ages 4 and 6 | Covered between ages 7 -18 if needed for catch-up |
| Rotavirus | One dose at 2 months<br>One dose at 4 months<br>One dose at 6 months | Covered between ages 7 - 18 if needed for catch-up |
| Varicella | One dose between 12 and 15 months<br>One dose between ages 4 and 6<br>Two doses, separated by 4 to 8 weeks, after age 50 | Covered between ages 7 - 18 if needed for catch-up |
| Zoster | One dose age 60 and greater | |

*For persons who meet the age requirements and who lack evidence of immunity

**Recommended if some other risk factor is present (medical, occupational, lifestyle or other indicators)

The Plan covers a wide range of medical services. However, certain services are not covered. Eligible medical expenses for covered services, subject to certain exclusions and limitations, include, but are not limited to, the following:

- The diagnosis or treatment of a sickness, illness, injury, or symptoms that result from a physical condition.
- Clinically appropriate services.
- Charges that do not exceed the reasonable and customary for the area.
- Charges for clinically appropriate services that meet professionally accepted, national standards of practice or quality and that are consistent with the conclusions of prevailing medical research.
- Charges for services or supplies that are not experimental, investigational, or unproven.

**Hospital Services**

Generally, the following hospital services expenses are covered under the Plan:

- Semiprivate room and board charges, and intensive care, cardiac care, and newborn care.
- Outpatient preadmission x-ray or laboratory testing.
- Operating room, recovery room, intravenous feedings, x-rays, laboratory tests, blood-transfusion services, prescription drugs and other eligible services provided during a hospital stay or in the Outpatient Department of a hospital.
- Pregnancy-related medical expenses for you or an enrolled dependent in connection with childbirth or miscarriage.

*Maternity Stay Benefits*

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if app.). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if app.).

*Surgical Services*

Generally, the following rules apply to surgical services expenses covered under the Plan:

- Assistant surgeon - Assistant surgeon's fees are covered if required by standard protocol. However, the fee is limited to no more than 20% of the fee approved for the primary surgeon. No assistant's fee is payable if the facility generally makes a qualified employee available for that purpose.
- Multiple surgical procedures - When more than one surgical procedure is performed during a single operating session, the eligible expense for the secondary procedures will be reduced.
- Repair of multiple traumatic injuries - When more than one injury is repaired during a single operating session, the eligible expense for the secondary procedures on the same bodily area or bodily system will be reduced.
- Cosmetic surgery – Cosmetic surgery that is necessary for the repair of an accidental injury.
- Dental services - Dental services or oral surgery that is provided by a dental provider or oral surgeon for the excision of a malignant tumor or when necessitated by an accidental injury is covered, provided such services are rendered with 12 months of the accident.
- Organ/Tissue transplants – covered as any other medical service.
- Reconstructive breast surgery - Reconstructive breast surgery is covered if performed in connection with a medically-necessary mastectomy (See the notice below concerning your rights under The Women's Health and Cancer Rights Act of 1998).

*Coverage for Reconstructive Surgery Following a Mastectomy*

The Women's Health and Cancer Rights Act of 1998 includes important protections for individuals who elect breast reconstruction in connection with a medically-necessary mastectomy. Under the terms of this federal act, coverage includes:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

This coverage is subject to the same deductible, coinsurance, and maximum limit provisions applicable to other medical benefits provided under the Plan.

**Emergency Services**

A medical emergency is any illness or injury that without immediate medical attention could reasonably be expected to place your life in jeopardy or could result in serious harm to bodily functions. For example, these situations are considered medical emergencies:

- Apparent heart attack
- Stroke
- Severe bleeding
- Obvious fractures

Colds, flu, nausea, sprains, earaches, and skin infections generally are not considered to be emergencies for the purpose of the Plan.

*Ambulance Transportation*

When you have an emergency, expenses for emergency transportation by an ambulance service are covered. The transportation must be from the place where you became ill or were injured to the nearest facility that can provide the necessary care.

**Exclusions**

The following are examples of the types of medical expenses which are excluded from covered charges under the Plan:

- Acupuncture - charges incurred for services or procedures involving acupuncture for any reason other than pain relief.
- Air Purification - charges for air conditioners, air-purification units, humidifiers, electric heating units and similar devices.
- Biofeedback - charges for biofeedback, recreational or educational therapy, or any other form of self-care or self-help training, or any related diagnostic testing.
- Birth Control - charges for contraceptive drugs, medicines, or devices used to prevent pregnancy, except as specifically indicated by the Plan.
- Blood - whole blood or plasma when donated or otherwise replaced by or on behalf of the patient.
- Charges Exceeding Reasonable and Customary - charges that are in excess of reasonable and customary allowance for the service provided. Reasonable and Customary means those charges made by eligible facilities and providers for services which do not exceed the general level of charges for the same services in the geographical region where the services are furnished.

- Charges Not A Covered Health Service - charges that are not a Covered Health Service. A Covered Health Service is a health service or supply that is provided for the purpose of preventing, diagnosing or treating an illness or injury and: is supported by national medical standards of practice; is consistent with conclusions of prevailing medical research that the service or supply has a beneficial effect on health outcomes; and is the most cost-effective method and yields a similar outcome to other available alternatives.
- Chelation Therapy - charges for chelation therapy, except for the treatment of heavy metal poisoning.
- Childhood Disorders - treatment of learning disorders, developmental delay, behavioral problems, mental retardation, or autism of childhood.
- Cosmetic Services - any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when: (a) necessitated by a non-occupational accidental injury; or (b) necessary to correct a condition, including a birth defect, which impairs the function of a body organ.
- Court Ordered Care – charges for care, confinement or treatment in a public or private institution as the result of a court order.
- Coverage Not in Effect - charges for services or supplies provided before your effective date of coverage under the Plan, or provided after your termination of coverage under the Plan.
- Custodial Care - charges for custodial care, including institutions that are custodial in nature such as homes for the aged, rest homes, and schools for the mentally retarded.
- Dental Procedures - charges for dental care or treatment, except for the excision of malignant tumors, and treatment by a physician, dentist or dental surgeon for accidental injury to natural teeth, as specifically indicated by the Plan.
- Diagnostic Hospital Admissions - confinement in a hospital for diagnostic purposes only, when such diagnostics could be performed in an outpatient setting.
- Ecological or Environmental Medicine - chelation or chelation therapy, orthomolecular substances, use of substances of animal, vegetable, chemical or mineral origin which are not specifically approved by the FDA as effective for treatment.
- Education or Training - charges for education or training of any kind, or to assist an individual in pursuing a trade or occupation. Charges for diabetic counseling by a registered dietician, physician or other covered provider are covered under the Plan.
- Employer's Medical Clinic - charges for services provided in a medical department or clinic maintained by the Company.
- Excess Prescriptions – charges for any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one (1) year from the physician's original order.
- Exercise Equipment and Health Clubs - exercising equipment, vibratory equipment, swimming or therapy pools, or enrollment in health, athletic or similar clubs.
- Experimental, Investigational or Unproven Services - charges for treatments, procedures, devices or drugs which the Plan Administrator determines, in the exercise of its discretion, are experimental, investigational or unproven services.
- Felony Participation - charges for an illness or injury sustained during the commission, or attempted commission, of an assault or felony, or injuries sustained while engaging in an illegal occupation, except that this exclusion does not apply to illness or injury sustained due to a medical condition or domestic violence.
- Genetic Counseling or Testing - counseling or testing for inherited (genetic) disorders.
- Hair Replacement - replacement of nonproductive hair follicles with productive follicles from another area of the scalp or body, for treatment of alopecia (baldness), or any other treatments, drugs, or supplies for baldness, except as specifically indicated in the Plan.
- Hearing Aids – charges for hearing aids and examinations for them.
- Holistic or Homeopathic Medicine - services, supplies or accommodations provided in connection with holistic or homeopathic treatment, including drugs.
- Hypnotherapy - treatment by hypnosis.

- Impregnation - services and supplies for or related to artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.
- Legal Prohibition - charges prohibited by any law of the jurisdiction in which you reside at the time the expense is incurred.
- Licensed Physician - charges for a physician or other provider acting outside the scope of the physician's or other provider's license.
- Maintenance Treatment - charges for services that do not seek to cure, or are provided during periods when the medical condition of the patient is not changing, or do not require continued administration by medical personnel.
- Marriage and Family Counseling - counseling to resolve family or marital difficulties.
- Mileage Costs and Claim Forms - charges for mileage costs, completion of claim forms, or preparation of medical reports.
- Military Service - charges for treatment of any sickness or injury incurred while in the military, naval or air service of any country.
- Nicotine Addiction - nicotine withdrawal programs, facilities and drugs or supplies, except as specifically indicated in the Plan.
- No-Charge Services - charges for which the service was furnished without charge or would have been furnished without charge if this Plan were not in effect.
- Non-Prescription Drugs - drugs which can be purchased over the counter and without a physician's written prescription (except for insulin, diabetic supplies, and syringes or the administration of insulin) and drugs for which there is a non-prescription equivalent available.
- Obesity and Weight Loss - charges for treatment for obesity, including diet control and weight reduction, when not required by a specifically identified condition of morbid obesity and disease etiology.
- Orthopedic Shoes - charges for orthopedic shoes (unless the shoes are permanently attached to braces), and other supportive appliances for the feet (except that orthotics are covered).
- Other Plan Provisions - charges under one coverage of this Plan to the extent that benefits are payable for the same charges under another coverage provided under this Plan.
- Personal Comfort or Convenience Items - charges for services or supplies provided for personal comfort and not necessary for the treatment of covered sickness, accidental injury or pregnancy, including, but not limited to, the purchase or rental of telephones, televisions, orthopedic mattresses, allergy-free pillows, blankets and/or mattress covers, non-hospital adjustable beds, waterbeds, motorized transportation equipment, elevators, escalators, professional medical equipment (such as blood pressure kits), or supplies or attachments to such equipment.
- Physician Approval - charges for any treatment not recommended or approved by a physician.
- Prescription Drugs - prescription drugs not specifically available under the prescription drug benefits portion of the Plan and the following excluded drugs and devices: non-federal legend drugs; fertility medications; insulin devices; contraceptive implants and devices; Minoxidil/Rogaine (and any other drug whose sole purpose is to promote hair growth); Retin A (only allowed through age 19); nutritional supplements; prescription vitamins (except prenatal); AIDS-related tests; steroids for body building; Relenza; Tamiflu; allergy sera; immunization agents and vaccines; biologicals, blood and blood plasma; experimental drugs; investigational drugs; unproven drugs; medical devices; over-the-counter drugs (except that benefits are available for over-the-counter diabetic supplies).
- Prosthetic Replacements - replacement of prosthetic devices, unless necessitated because of wear or bodily change.
- Public Programs - charges made for services or supplies which can be paid for by any government agency, even if you waive rights to those services or supplies.
- Radial Keratotomy - charges incurred for services or procedures involving radial keratotomy, refractive keratoplasty, LASIK, or similar procedures.
- Routine Foot Care - charges for non-surgical treatment of the feet, including treatment of corns, calluses, toenails or other routine foot care, unless the charges are for removal of nail roots or for the treatment of a metabolic or peripheral-vascular disease.

- Routine or Preventive Care - charges for examinations and procedures performed for screening, survey, or research, or for pre-marital examinations, camp, or employment purposes, or for routine examinations or check-ups or immunizations, except as specifically indicated in the Plan.
- Sales Tax – charges for sales tax or other tax imposed by law.
- Self-Procured Services - services rendered if you are not under the regular care of a physician and for services, supplies or treatment, including any period of hospitalization, which are not recommended, approved and certified as necessary and reasonable by a physician.
- Services of an Immediate Relative - charges for services which are self-administered or rendered by an immediate relative.
- Sex Change Procedures, Services or Supplies - sex change counseling, or treatment or services or supplies incident to sex change surgery or any resulting complications.
- Sex Counseling or Treatment - treatment, therapy or counseling for sexual dysfunctions or inadequacies not related to organic disease.
- Sleep Disorders - charges for sleep disorders, unless there is documented evidence of sleep apnea.
- Speech Therapy - charges for speech therapy to correct a non-organic speech defect.
- Sterilization Reversal - charges in connection with surgery to reverse voluntary sterilization.
- Technical Medical Assistance - charges for technical medical assistance or standby physician services.
- Telephone Consultations - charges for telephone consultations.
- Temporomandibular Joint Dysfunction - nonmedical treatment of TMJ.
- Travel Expenses - charges for travel expenses, whether or not recommended by a physician, except as specifically provided under the organ/tissue transplant benefit.
- Treatment Not Provided by a Physician - charges for treatment not provided by a physician or other covered provider.
- Treatment Outside the U.S. - charges incurred outside of the United States if you travel to such a location for the primary purpose of obtaining such services, drugs or supplies.
- U.S. Government Hospitals - charges for services or supplies provided by the Veterans Administration or in any hospital or institution owned, operated, or maintained by the United States government for a service-related sickness or injury.
- Unnecessary Hospital Treatment - charges for hospital services not consistent with and not required in the management and treatment of a sickness or injury for which you are admitted.
- Vision Expenses - charges for eyeglasses or contact lenses, except as necessary following cataract surgery, and examinations for their prescription or fitting, orthoptic, vision therapy or other special vision procedures.
- Vitamins and Nutritional Supplements – charges for nutritional supplements, unless the patient's sole nutrition (liquid or medication) is by gastrostomy/NG tube feeding and such supplements are deemed as covered by the Plan; or charges for vitamins, even if a written prescription is provided, except that prescription pre-natal vitamins are covered.
- Vocational Testing or Training - vocational testing, evaluation, counseling or training.
- War-Related Expenses - charges for treatment of any illness or injury caused by war, act of war, riot, civil disobedience, nuclear explosion, nuclear accidents, or similar event whether such event be declared or undeclared war, except that this exclusion does not apply to illness or injury sustained due to a medical condition or domestic violence.
- Wigs or Wig Maintenance – purchase of more than one synthetic wig or its equivalent, for hair loss due to sickness or medical treatment (such as chemotherapy); or the repair, replacement or maintenance (cleaning, etc.) of a wig.
- Work-Related Conditions - any condition which arises from or is sustained in the course of any occupation or employment for compensation, or any condition for which coverage is available, in whole or in part, under any Workers' Compensation Act or similar legislation.

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**From:** Botwinick, Alexandra (HHS/OCIIO)
**Sent:** Tuesday, October 26, 2010 3:35 PM
**To:** 'Lwalker@darden.com'
**Subject:** Waiver of the Annual Limits Requirements of PHS Act Section 2711

**Importance:** High

**Attachments:** Updated Jan 1 Approval Letter .pdf
Ms. Walker,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section for Darden Restaurants. HHS has reviewed your application and made its determination. Please see the attached letter.

Please confirm receipt of this letter by replying to this e-mail address with a copy to OCIIOOversight@hhs.gov.

Please let me know if I can be of further assistance.

Sincerely,

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
alexandra.botwinick@hhs.gov

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Consumer Information and
Insurance Oversight
Washington, DC 20201

**Date:** October 2010

**From:** Steve Larsen, Director, Office of Oversight

**Subject:** Application for Waiver of the Annual Limits Requirements of PHS Act Section 2711

Dear Waiver Applicant:

Section 2711(a)(2) of the Public Health Service Act (PHS Act), as added by the Patient Protection and Affordable Care Act (Affordable Care Act), requires the Secretary to impose restrictions on the imposition of annual limits on the dollar value of essential health benefits (as defined in section 1302(b) of the Affordable Care Act) for any participant or beneficiary in a new or existing group health plan or a new policy in the individual market for plan or policy years beginning on or after September 23, 2010 and prior to January 1, 2014. Specifically, the Secretary is granted the authority to determine what constitutes a "restricted annual limit" that can still be imposed under such plans or policies prior to January 1, 2014.

The interim final regulations published on June 28, 2010 (codified at 26 CFR § 54.9815-2719T; 29 CFR § 2590.715-2719; and 45 CFR §147.126) established such restricted annual limits. The regulations also provided that these restricted annual limits may be waived by the Secretary of Health and Human Services (HHS) if compliance with the interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums. Pursuant to the regulation, HHS issued guidance on September 3 regarding the scope and process for applying for a waiver.

The Office of Consumer Information and Insurance Oversight, Office of Insurance Oversight received and processed your application for the plan(s) or policy(ies) year beginning January 1, 2011. We have determined that your application has met the criteria to obtain a waiver of the restricted annual limits requirements because compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies. To the extent you make any change to your benefit package after March 23, 2010, you must determine whether the change(s) will trigger loss of grandfathering status pursuant to 45 CFR §147.140(g)(1).

An approval of your request for waiver of the restricted annual limits requirements granted under this process applies only to the annual limit(s) provided in your application for the plan or policy year beginning between September 23, 2010 and September 23, 2011. This waiver only applies to the annual limits requirements in Section 2711 of the ACA and does not apply to any other requirement of the Affordable Care Act, ERISA, the IRS Code or the PHS Act. Further, a group

health plan or health insurance issuer must reapply for any subsequent plan or policy year prior to January 1, 2014 when this waiver expires in accordance with future guidance from HHS. HHS may modify this waiver approval process memorandum and other relevant information.

If you have any questions regarding this letter, please email OCIIOOversight@hhs.gov.

From: Lynda Walker [LWalker@darden.com]
Sent: Friday, October 29, 2010 3:35 PM
To: Botwinick, Alexandra (HHS/OCIIO)
Cc: OCIIO Oversight
Subject: RE: Waiver of the Annual Limits Requirements of PHS Act Section 2711

Follow Up Flag: Follow up
Flag Status: Red

Dear Ms. Botwinick,

Thank you for your time and effort on Darden's behalf. We appreciate your consideration and grant of a waiver for our plan.

Best regards,

Lynda Walker

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From: Botwinick, Alexandra (HHS/OCIIO) [Alexandra.Botwinick@hhs.gov]
Sent: Tuesday, October 26, 2010 3:34 PM
To: Lynda Walker
Subject: Waiver of the Annual Limits Requirements of PHS Act Section 2711

Ms. Walker,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section for Darden Restaurants. HHS has reviewed your application and made its determination. Please see the attached letter.

Please confirm receipt of this letter by replying to this e-mail address with a copy to OCIIOOversight@hhs.gov.

Please let me know if I can be of further assistance.

Sincerely,

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
alexandra.botwinick@hhs.gov<mailto:alexandra.botwinick@hhs.gov>