BLACKWATER COMMUNITY SCHOOL

EMPLOYEE BENEFIT PLAN

PPO PLAN OPTION

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

EFFECTIVE DATE: OCTOBER 1, 2015

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ADOPTION

Blackwater Community School has caused this Blackwater Community School Employee Benefit Plan PPO Plan Option ***(Plan)*** to take effect as of the first day of October 2015, at Coolidge, Arizona. I have read the document herein and certify the document reflects the terms and conditions of the employee welfare benefit plan as established by Blackwater Community School.

PLAN ADMINISTRATOR: BLACKWATER COMMUNITY SCHOOL

BY:_____ DATE:_____

SUMMARY PLAN DESCRIPTION

Name of Plan:

Blackwater Community School Employee Benefit Plan PPO Plan Option

Name, Address and Phone Number of Employer/Plan Sponsor:

Blackwater Community School
3652 E. Blackwater School Road
Coolidge, Arizona 85128
Phone: (520) 215-7910

Employer Identification Number:

74-2422892

Plan Number:

501

Type of Plan:

Group Health Plan providing coverage for: medical and prescription drug benefits

Type of Administration:

Contract administration: The processing of claims for benefits under the terms of the ***Plan,*** is provided through a company contracted by the ***employer*** and shall hereinafter be referred to as the ***claims processor.***

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:

Blackwater Community School
3652 E. Blackwater School Road
Coolidge, Arizona 85128
Phone: (520) 215-7910

Eligibility Requirements:

For detailed information regarding a person's eligibility to participate in the ***Plan,*** refer to the following sections:

Eligibility
Enrollment
Effective Date of Coverage

Schedule of Benefits:

Eligible, enrolled ***employees*** and ***dependents*** are covered for the benefits under this ***Plan.*** Refer to the section entitled, *Schedule of Benefits.* The *Schedule of Benefits* will list all applicable ***maximum benefits;*** the extent to which preventive services are covered under the ***Plan;*** whether, and under what circumstances, existing and new drugs are covered under the ***Plan;*** whether, and under what circumstances, coverage is provided for medical tests, devices and procedures.

Procedures for Qualified Medical Child Support Orders:

Employees and ***dependents*** may obtain, without charge, a copy of the ***employer's*** procedures governing Qualified Medical Child Support Orders (QMCSO).

Employee/Dependent Contributions:

The amount of contributions paid for by the ***employer*** on behalf of the ***employee*** and the ***employee's dependents*** is determined by the ***employer.*** An ***employee*** may contact the ***employer*** for a current listing of the contribution schedule.

Employee/Dependent Cost Sharing:

All ***covered expenses*** are subject to applicable ***Plan*** provisions including, but not limited to: deductible, ***copay, coinsurance*** and ***maximum benefit*** provisions as shown in the *Schedule of Benefits*, unless otherwise indicated. Any expenses ***incurred*** by the ***covered person*** for services, supplies or treatment provided will not be considered ***covered expenses*** by this ***Plan*** if they are greater than the ***customary and reasonable amount*** for ***nonpreferred providers.***

Provider Network:

The ***Plan*** uses a ***Preferred Provider Organization***. A ***preferred provider*** is a ***physician, hospital*** or ancillary service provider which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a reduced rate for services rendered to ***covered persons.*** This is known as the ***negotiated rate.*** The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate. Covered persons*** should contact the Human Resources Department for a current listing of ***preferred providers.*** This PPO listing is provided at no charge.

Under the ***Plan, covered persons*** have the choice of using either a ***preferred provider*** or a ***nonpreferred provider.*** Because the ***covered person*** and the ***Plan*** save money when services, supplies or treatment are obtained from providers participating in the ***Preferred Provider Organization,*** benefits are usually greater than those available when using the services of a ***nonpreferred provider.*** Refer to the section entitled, *Schedule of Benefits.*

The sections entitled, *Schedule of Benefits* and *Preferred Provider or Nonpreferred Provider* will address provisions governing the use of ***preferred providers***, the composition of the provider network, and whether and under what circumstances coverage is provided for out-of-network services; any conditions or limits on the selection of a primary care provider or providers of specialty medical care; and any condition or limits applicable to obtaining emergency medical care.

Utilization Review (Precertification):

Utilization Review is the process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care, also known as precertification. ***Utilization Review*** can eliminate unnecessary services, ***hospitalizations,*** and shorten ***confinements*** while improving quality of care and reducing costs to the ***covered person*** and the ***Plan.*** Certain procedures and/or treatments require precertification. Failure to comply with the precertification procedures may result in a reduction of benefits or loss of benefits. Refer to the sections entitled, *Schedule of Benefits* and *Utilization Review* for complete details.

Loss of Benefits:

For detailed information regarding a person being ineligible for benefits through reaching ***maximum benefit*** levels, reduction in benefits, or termination of coverage**,** refer to the following sections:

Schedule of Benefits
Utilization Review
Termination of Coverage
Plan Exclusions

Third Party Liability Reimbursement/Subrogation:

The ***Plan*** maintains the right to seek reimbursement on its own behalf: the right of subrogation. The ***Plan*** also reserves the right to reimbursement upon a ***covered person's*** (a covered ***employee*** or a covered dependent) receipt of settlement, judgment, or award: the right of reimbursement. The ***Plan*** reserves the right of recovery, either by subrogation or reimbursement, for ***covered expenses*** payable by the ***Plan*** which are a result of ***illness*** or ***injury***. The ***Plan*** shall be reimbursed from the first monies recovered as the result of judgment, settlement or otherwise. (This is known as "Pro tanto" subrogation.) This right includes the ***Plan's*** right to receive reimbursement from uninsured or underinsured motorist coverage and no-fault coverage.

Accepting benefits from this ***Plan*** automatically assigns to it any rights the ***covered person*** may have to recover benefits from any party, including an insurer or another group health program. This right of recovery allows the ***Plan*** to pursue any claim which the ***covered person*** may have against any party, group health program or insurer, whether or not the ***covered person*** chooses to pursue that claim. This includes a right to recover from no-fault auto insurance carriers in a situation where no third party may be liable, or from any uninsured or underinsured motorist coverage where the recovery was triggered by the actions of a party which caused or contributed to the payment of benefits under this ***Plan.*** This also includes a right to recover from amounts the ***covered person*** received from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid benefits prior to a determination that the medical expenses arose out of and in the course of employment. Payment by workers' compensation will be presumed to mean that such a determination has been made.

Failure to reimburse the ***Plan*** for ***covered expenses*** paid by the ***Plan*** that were also paid by a third party otherwise responsible shall result in a reduction of future claim benefits of a ***covered person*** up to the aggregate amount the ***Plan*** has paid.

For detailed information on the ***Plan's*** rights under third party liability reimbursement and/or subrogation, refer to the section entitled, *Third Party Liability Reimbursement/Subrogation.*

Plan Termination:

The ***employer*** reserves the right to terminate the ***Plan***, in whole or in part, at any time. Upon termination, the rights of the ***covered persons*** to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the ***Plan*** will be communicated to the ***covered persons.***

Upon termination of this ***Plan,*** all claims ***incurred*** prior to termination, but not submitted to either the ***employer*** or ***claims processor*** within three (3) months of the ***effective date*** of termination of this ***Plan,*** will be excluded from any benefit consideration.

The allocation and disposition of any assets of the ***Plan*** upon termination of the ***Plan*** shall include appropriate payment of ***Plan*** expenditures including administrative fees and ***covered expenses*** for ***covered persons***.

Plan Modification/Amendment:

The ***employer*** may modify or amend the ***Plan*** from time to time at its sole discretion, and such amendments or modifications which affect ***covered persons*** will be communicated to the ***covered persons*** within sixty (60) days after the adoption of the amendment***.*** Any such amendments shall be in writing, setting forth the modified provisions of the ***Plan,*** the ***effective date*** of the modifications, and shall be signed by the ***employer's*** designee. Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***employer,*** or a written copy thereof shall be deposited with such master copy of the ***Plan.***

Continuation of Coverage (COBRA) Information:

Once coverage under the ***Plan*** becomes effective for ***employees*** and their ***dependents,*** those individuals have the right to continue coverage under the ***Plan*** should loss of coverage occur due to specified reasons. This period of continuation of coverage has specified time limitations, depending upon the reason for loss of coverage. ***Employees*** and ***dependents*** who elect continuation of coverage under this provision are responsible for payment of the full costs of

the ***Plan,*** including a two percent (2%) administration charge. For detailed information concerning continuation of coverage, refer to the section entitled, *Continuation of Coverage.*

Source of Plan Contributions:

Contributions for ***Plan*** expenses are obtained from the ***employer*** and from the covered ***employees*** for their covered ***dependents.*** The ***employer*** evaluates the costs of the ***Plan*** based on projected ***Plan*** expenses and determines the amount to be contributed by the ***employer*** and the amount to be contributed by the covered ***employees.***

Funding Method:

The ***employer*** pays ***Plan*** benefits and administration expenses directly from general assets. Contributions received from ***covered persons*** are used to cover ***Plan*** costs and are expended immediately.

Ending Date of Plan Year:

June 30th

Procedures for Filing Claims:

The following is intended to provide a general overview of the procedures for filing a claim, providing notice of benefit determinations, including "pre-service claims" known as ***Utilization Review (precertification)***, and appealing denied claims. For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Claim Filing Procedures.* For detailed information on how to go through the ***Utilization Review*** process, or file an appeal on a decision from the ***Utilization Review Organization***, refer to the section entitled *Utilization Review.* The designated ***claims processor*** is: Summit Administration Services, Inc., P. O. Box 25160, Scottsdale, AZ 85255, 1-888-690-2020.

General Requirements:

1. The ***Plan*** may not have any provision that unduly inhibits or hampers claims filing or processing.

2. The ***Plan*** may not prohibit an authorized representative from acting on behalf of a ***covered person***.

3. The ***Plan*** must have administrative processes and safeguards to ensure that claim decisions are made based upon plan documents and have been consistently applied for similarly situated individuals.

4. Upon a ***covered person's*** request after a claim denial, the ***Plan*** must provide any relevant information verifying that it complied with its procedures.

Specific Requirements:

1. Claim Deficiencies

   A. Urgent Care Claims: If the claim is incomplete, the ***Plan*** must notify the ***covered person*** of the deficiency and specify what information is missing within seventy-two (72) hours after receipt of the claim. The ***covered person*** shall be afforded a reasonable amount of time, but no less than forty-eight (48) hours to provide the missing information. The ***Plan*** must then make the decision no more than forty-eight (48) hours after the earlier of: the ***Plan's*** receipt of the missing information or the end of the additional period of time.

   B. Pre-service Claims: In the event a ***covered person*** or his authorized representative submits a pre-service claim that does not comply with the ***Plan's*** claims procedures, within five (5) calendar days of the discovery of the defect, the ***Plan*** must provide the ***covered person*** or his representative with oral or written notice of the deficiency and the steps needed to cure it. If the

covered person or his representative requests such a notice to be in writing, the ***Plan*** must do so. The ***covered person*** shall have no less than forty-five (45) days to provide the information.

2. Timing of Notification of Benefit Determination The ***covered person*** shall be notified of the ***Plan's*** benefit determination on review as follows:

   A. Urgent Care Claims (precertification): If the ***physician*** classifies a claim as urgent, the ***Plan*** must recognize the claim as urgent. ***Covered persons*** must be notified of a benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after the receipt of the claim.

   B. Pre-service Claims: The ***Plan*** must make a benefit determination within fifteen (15) days after receipt of request from a ***covered person***. This time period may be extended for another fifteen (15) days if it is necessary because of matters beyond the ***Plan's*** control, and if the ***Plan*** notifies the ***covered person*** of those circumstances and the expected date of the decision before the end of the first fifteen (15) day period.

   C. Concurrent Care Claims: When a ***covered person*** requests extension of an on-going course of treatment beyond that which the ***Plan*** has approved, the ***Plan*** must make a decision regarding the extension within seventy-two (72) hours after receipt of the request and notify the ***covered person*** of the decision, provided the request for the extension was made at least seventy-two (72) hours before the end of the treatment which was already approved.

   D. Post-service Claims: The ***Plan*** shall notify the ***covered person*** of an adverse benefit determination not more than thirty (30) days after receipt of the claim by the ***Plan***. This time period may be extended for fifteen (15) days if it is necessary because of matters beyond the ***Plan's*** control, and if the ***Plan*** notifies the ***covered person*** of those circumstances and the expected date of decision before the end of the thirty (30) day period. This Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. The ***employee*** will be allowed up to forty-five (45) calendar days from receipt of the Notice of Extension to provide the additional information. The ***Plan*** will then make a claim determination within a reasonable period but not later than fifteen (15) calendar days from the date the ***Plan*** receives the additional information.

3. Appeals. The ***Plan*** may not require a ***covered person*** to file more than two (2) appeals before he is able to file a lawsuit.

   A. Urgent Care Claims (precertification): If certification of ***medical necessity*** is denied and the ***covered person*** appeals the denial, the ***Plan*** must render a review decision as soon as possible, but no more than seventy-two (72) hours after receiving the appeal.

   B. Pre-service Claims (precertification): If certification of ***medical necessity*** is denied and the ***covered person*** appeals the denial, the ***Plan*** must render a review decision within thirty (30) days after receiving the appeal. If the ***Plan*** provided for two (2) levels of review, both appeals must be decided within that thirty (30) day time period, and one must be decided within fifteen (15) days after receipt of the appeal. The ***covered person*** has 180 days to appeal a denial.

   C. Concurrent Care Claims: If the ***Plan*** has approved an on-going course of treatment, and then determines that such treatment should be reduced or terminated, the ***Plan*** must notify the ***covered person*** of this decision far enough in advance of the reduction or termination to allow the ***covered person*** to appeal the decision and obtain a review before the reduction or termination takes effect. This does not apply to an amendment or termination of the ***Plan.***

D. Post-service Claims: If a claim for benefits is denied by the ***Plan*** and the ***covered person*** appeals the denial, the ***Plan*** must render a review decision within sixty (60) days after receiving the appeal. If the ***Plan*** provides for two levels of review, both appeals must be decided within the sixty (60) day time period, and one must be decided within thirty (30) days following receipt of the appeal. The ***covered person*** has 180 days to appeal a claim denial.

Internal and External Appeal Process:

Refer to *Claim Filing Procedure, Internal and External Appeal Process* for more details.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act:

Under federal law, group health plans offering group health coverage generally may not 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 delivery by cesarean section. However, the ***Plan*** may pay for a short stay if the attending provider (e.g. the ***physician,*** nurse midwife, or physician assistant,) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan may not, under federal law, require that a ***physician*** or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours. However, to use certain providers or facilities, or to reduce the out-of-pocket cost, a ***covered person*** may be required to obtain precertification. For information on precertification, refer to the section entitled, *Utilization Review.*

Privacy Rights:

This ***Plan*** complies with the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). ***Covered Persons*** have the following rights under the HIPAA Privacy Rule:

1. The right to request restriction on the uses and disclosures of medical information. The ***employer*** is not required to agree to the requested restriction if the request is deemed unreasonable or would hinder the routine processing of claims.

2. The ***employer*** must give a ***covered person*** the opportunity to inspect or obtain copies of their medical information with exception for psychotherapy notes and information compiled for use in a civil, criminal or administrative action.

3. The ***employer*** must provide ***covered persons*** the opportunity to amend their medical information for as long as the ***employer*** maintains it for the ***Plan***. The ***employer*** may deny an individual's request for amendment if it determines that the medical information was not created by the ***Plan.***

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Utilization Review, Preferred Provider Organization, Medical Expense Benefit, Prescription Drug Program* and *Plan Exclusions.*

A complete listing of ***preferred providers*** can be obtained from the Human Resources Department. Limitations are combined maximums for ***preferred*** and ***nonpreferred*** providers. Certain words and terms used herein are defined and are shown in ***bold and italics*** throughout the document. Refer to the section entitled, *Definitions.* All ***Plan*** benefits are calculated based on a "benefit year." The benefit year is January 1st through December 31st.

MEDICAL BENEFITS

Coinsurance:

After the individual or family deductible has been satisfied, the ***Plan*** pays the percentage listed on the following pages for ***covered expenses*** at the ***customary and reasonable amount*** for ***nonpreferred providers***, or the percentage of the ***negotiated rate*** for ***preferred providers***. This is known as the ***Plan's coinsurance.*** The ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the ***negotiated rate*** for ***preferred providers.*** For ***nonpreferred providers***, the ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the billed amount. The ***covered person's*** portion of the ***coinsurance*** represents the out-of-pocket expense limit.

For example, if the ***Plan*** pays seventy percent (70%) of the ***customary and reasonable amount*** for ***nonpreferred provider*** services, the ***covered person*** is responsible for the remaining thirty percent (30%) of the ***customary and reasonable amount.*** This thirty percent (30%) shall apply toward the out-of-pocket expense limit. However, any amount that the ***nonpreferred provider*** bills in excess of the ***customary and reasonable amount*** is not a ***covered expense*** of the ***Plan*** and does not apply toward the out-of-pocket expense limit. The ***covered person*** is responsible to pay any amount billed by a ***nonpreferred provider*** in excess of the ***customary and reasonable amount.***

Once the out-of-pocket expense limit has been reached, the ***Plan*** pays one hundred percent (100%) of ***incurred covered expenses*** for the remainder of the ***benefit year***. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit,* for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance.***

BENEFIT DESCRIPTION & BENEFIT LIMITATION The ***benefit year*** is January 1st through December 31st.	PREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***negotiated rate.***	NONPREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***customary and reasonable amount.***

Precertification Penalty Failure to obtain precertification for services requiring precertification shall result in a $300 penalty deductible applying to ***covered expenses*** first, then any applicable ***benefit year*** deductible, then the ***Plan's coinsurance*** applies. No benefits payable for transplants without precertification.		
Benefit Year **Deductible** Individual (Per Person) Family (Aggregate)	 $2,000 $4,000	 $4,000 $8,000
Out-of-Pocket Expense Limit Per *Benefit Year*: (includes medical and prescription ***copays*** and ***coinsurance*****)** Individual Family (Aggregate) Refer to *Medical Expense Benefit,* ***Benefit Year*** *Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.	 $6,000 $12,000	 $8,000 $16,000
Inpatient Hospital Precertification required.	80%	50%
Outpatient Hospital/Ambulatory Surgical Facility Specified procedures require precertification. See *Utilization Review.*	80%	50%
Ambulance Service	80% after ***PPO*** deductible	20% after ***PPO*** deductible.
Emergency Room Services	80% after ***PPO*** deductible	20% after ***PPO*** deductible
Physician's Services Home, Inpatient, Office Visit Surgery - Physician's Office Surgery - Other Pathology Anesthesiology Radiology	 80% 80% 80% 80% 80% 80%	 50% 50% 50% 50% 50% 50%
Extended Care Facility Precertification required. Limitation: 90 days ***maximum benefit*** per ***benefit year***	80%	50%
Home Health Care Precertification required.	80%	50%
Hospice Care Precertification required.	80%	50%
Durable Medical Equipment	80%	50%
Preventive Care Services All preventive care services as recommended by the U.S. Preventive Services Task Force	100%; deductible waived For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	Not Covered

BENEFIT DESCRIPTION & BENEFIT LIMITATION The ***benefit year*** is January 1st through December 31st.	PREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***negotiated rate.***	NONPREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***customary and reasonable amount.***

Pediatric Health Care	100%; deductible waived	Not Covered
	For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	
Immunizations	100%. deductible waived	Not Covered
	For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	
Preventive Care: Well Woman Preventive Services Includes: Well Woman Visits; Screening for gestational diabetes; Human Papillomavirus testing; counseling for sexually transmitted infections; counseling & screening for human immune-deficiency virus; contraceptive methods & counseling; breast-feeding support, supplies and counseling; screening & counseling for interpersonal & domestic violence;	100%; deductible waived	Not Covered
	For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	
Routine Mammogram	100%: deductible waived	50%: deductible waived
Mental & Nervous Disorders/Chemical Dependency ***Inpatient*** Services Precertification required	80%	50%
Outpatient Services	80%	50%
Therapy Services (Radiology, Chemotherapy, Dialysis)	80%	50%
Rehabilitative Services (Physical, Speech, Occupational) Limited to 20 visits per ***benefit year*** for ***outpatient*** physical and occupational therapy combined Limited to 20 visits per ***benefit year*** for ***outpatient*** speech therapy Additional benefits for services of a ***preferred provider*** that exceed the annual maximum may be available if determined to be ***medically necessary*** by the ***Utilization Review Organization.*** Such benefits shall be payable at 50% up to a maximum out-of-pocket expense of $500. After the maximum out-of-pocket has been reached, benefits shall be payable at 100%.	80%; deductible waived The deductible is not waived for evaluations prior to therapy.	50%; deductible waived The deductible is not waived for evaluations prior to therapy.
Chiropractic Care Limitation: 20 visits ***maximum benefit*** per ***benefit year***	80%	50%

BENEFIT DESCRIPTION & BENEFIT LIMITATION The ***benefit year*** is January 1st through December 31st.	PREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***negotiated rate.***	NONPREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***customary and reasonable amount***
Prosthetics	80%	50%
Dental Injury	80%	80%
Transplants **Limited to $200 per day/$10,000 while covered by this Plan for travel and lodging with no deductible or coinsurance**	80%	50%
Temporomandibular Joint Dysfunction Limited to $1,000 ***maximum benefit*** while covered by this ***Plan***.	80%	50%
Diagnostic Testing, Lab and X-ray Services	80%	50%
Neuropsychological and Cognitive Testing Limited to 10 hours of testing per calendar year	80%	50%
Cataract Surgery Limited to $500 ***maximum benefit*** for initial pair of eyeglasses or contacts following surgery	80%	50%
Hearing Services and Devices Limited to $25,000 while covered by this ***Plan.***	80%	50%
All Other Covered Expenses	80%	50%

PRESCRIPTION DRUG PROGRAM

POINT OF PURCHASE	BENEFIT	SUPPLY LIMITATION
Participating Pharmacy	100% ***Plan*** payment after ***copay****:* Contraceptives & other non-prescription drugs as mandated by the Patient Protection and Affordable Care Act: $0 ***copay*** Generic & Diabetic Supplies & Drugs: $5 ***copay*** Formulary Brand Name: $25 ***copay*** Non-Formulary Brand Name: $75 ***copay*** Specialty Drugs: $200 ***copay***	30 day supply
Nonparticipating Pharmacy	Not Covered	
Mail Order	Contraceptives & other non-prescription drugs as mandated by the Patient Protection and Affordable Care Act: $0 ***copay*** Generic & Diabetic Supplies & Drugs: $5 ***copay*** Formulary Brand Name: $25 ***copay*** Non-Formulary Brand Name: $75 ***copay*** Specialty Drugs: $200 ***copay***	90 day supply
Out-of-Pocket Expense Limit	The ***copays*** under the *Prescription Drug Program* shall apply toward the *Medical Expense Benefit,* ***preferred provider*** Out-of-Pocket Expense Limit. Refer to Out-of-Pocket Expense Limit Exclusions for a listing of charges not applicable.	

UTILIZATION REVIEW

Utilization review is the process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care. ***Utilization Review*** can eliminate unnecessary services, ***hospitalizations,*** and shorten ***confinements*** while improving quality of care and reducing costs to the ***covered person*** and the ***Plan.***

Certification of ***medical necessity*** and appropriateness by the ***Utilization Review Organization*** does not establish eligibility under the ***Plan*** nor guarantee benefits.

PRECERTIFICATION

Hospital/Outpatient Surgery

All medical, surgical, psychiatric, substance abuse ***hospital*** admissions, including acute ***hospital*** admissions long term acute admissions. Acute rehabilitation, acute detoxification and specified ***outpatient hospital/ambulatory surgical facility*** procedures are to be certified in advance of the proposed ***confinement*** or surgery (precertification) by the ***Utilization Review Organization,*** except for ***emergencies***. The ***covered person*** or their representative should call the ***Utilization Review Organization*** prior to admission. ***Emergency hospital*** admissions are to be reported to the ***Utilization Review Organization*** within forty-eight (48) hours following admission, or on the next business day after admission.

Covered persons should contact the Utilization Review Organization by calling: 1-800-944-9401

Group health plans 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 forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. If delivery occurs in the ***hospital,*** the 48-hour period, or 96-hours, begins at the time of delivery. If delivery occurs outside the ***hospital*** and is later ***confined*** to the ***hospital*** in connection with childbirth, the period begins at the time of the ***hospital*** admission. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law require that a provider obtain authorization from the ***Plan*** for prescribing a length of stay not in excess of the above periods. If a newborn remains hospitalized beyond the time frames specified above, the ***confinement*** must be precertified.

After admission to the ***hospital,*** the ***Utilization Review Organization*** will continue to evaluate the ***covered person's*** progress through ***concurrent review*** to monitor the length of ***confinement*** and ***medical necessity*** of treatment. If the ***Utilization Review Organization*** disagrees with the length of ***confinement*** recommended by the ***physician,*** the ***covered person*** and the ***physician*** will be advised. If the ***Utilization Review Organization*** determines that continued ***confinement*** is no longer necessary, additional days will not be certified. **Benefits payable for days not certified as *medically necessary* by the *Utilization Review Organization* shall be denied.**

However, in the event that a ***retrospective review***, (a review completed after the event), determines that the hospitalization or surgery did not exceed the amount that would have been approved had the precertification been completed, there will be no penalty assessed and the amount of any deductible and/or ***coinsurance*** will count towards the satisfaction of the ***covered person's*** maximum out-of-pocket expense.

PRECERTIFICATION PENALTY

For the purpose of determining benefits payable if certification of ***medical necessity*** is not obtained, ***covered expenses*** shall be subject to a three hundred dollar ($300) penalty deductible applying to ***covered expenses*** first, then any applicable ***benefit year*** deductible, then the ***Plan's coinsurance*** applies. In addition no benefits shall be payable for transplants if precertification is not obtained.

NOTIFICATION DEFICIENCIES

Urgent Care Claims: If the request for precertification is incomplete, the ***Utilization Review Organization*** must notify the ***covered person*** of the deficiency and specify what information is missing within seventy-two (72) hours after receipt of the claim. The ***covered person*** shall be afforded a reasonable amount of time, but no less than forty-eight (48) hours to provide the missing information. The ***Plan*** must then make the decision no more than forty-eight (48) hours after the earlier of: the ***Plan's*** receipt of the missing information or the end of the additional period of time.

Pre-service Claims: In the event a ***covered person*** or his authorized representative submit a pre-service claim that does not comply with the ***Plan's*** claims procedures, within five (5) calendar days of the discovery of the defect, the ***Plan*** must provide the ***covered person*** or his representative with oral or written notice of the deficiency and the steps needed to cure it. If the ***covered person*** or his representative requests such a notice to be in writing, the ***Plan*** must do so. The ***covered person*** shall have no less than forty-five (45) days to provide the information.

TIMING OF NOTIFICATION

The ***covered person*** shall be notified of the ***Plan's*** benefit determination on review as follows:

Urgent Care Claims (precertification): If the ***physician*** classifies a claim as urgent, the ***Plan*** must recognize the claim as urgent. ***Covered persons*** must be notified of decisions as soon as possible, but no more than seventy-two (72) hours after receipt of the claim.

Pre-service Claims: The ***Plan*** must make a benefit determination within fifteen (15) days after receipt of request from a ***covered person***. This time period may be extended for another fifteen (15) days if it is necessary because of matters beyond the ***Plan's*** control, and if the ***Plan*** notifies the ***covered person*** of those circumstances and the expected date of the decision before the end of the first fifteen (15) day period.

Concurrent Care Claims: When a ***covered person*** requests extension of an on-going course of treatment beyond that which the ***Plan*** has approved, the ***Plan*** must make a decision regarding the extension within twenty-four (24) hours after receipt of the request and notify the ***covered person*** of the decision, provided the request for the extension was made at least twenty-four (24) hours before the end of the treatment which was already approved.

PRECERTIFICATION APPEAL PROCESS

In the event certification of ***medical necessity*** is denied by the ***Utilization Review Organization,*** the ***covered person*** may appeal the decision. The ***covered person*** may call the ***Utilization Review Organization*** for more information concerning the appeal process.

Urgent Care Claims (precertification): If certification of ***medical necessity*** is denied and the ***covered person*** appeals the denial, the ***Utilization Review Organization*** must render a review decision as soon as possible, but no more than seventy-two (72) hours after receiving the appeal.

Pre-service Claims (precertification): If certification of ***medical necessity*** is denied and the ***covered person*** appeals the denial, the ***Utilization Review Organization*** must render a review decision within thirty (30) days after receiving the appeal. If two (2) levels of review are provided, both appeals must be decided within that thirty (30) day time period, and one must be decided within fifteen (15) days after receipt of the appeal. The ***covered person*** has 180 days to appeal a denial.

Concurrent Care Claims: If the ***Utilization Review Organization*** has approved an on-going course of treatment, and then determines that such treatment should be reduced or terminated, the ***Utilization Review Organization*** must notify the ***covered person*** of this decision far enough in advance of the reduction or termination to allow the ***covered person*** to appeal the decision and obtain a review before the reduction or termination takes effect. This does not apply to an amendment or termination of the ***Plan.***

CASE MANAGEMENT

In cases where the ***covered person's*** condition is expected to be or is of a serious nature, the ***Utilization Review Organization*** may arrange for review and/or ***Case Management*** services from a professional qualified to perform such services. The ***employer*** shall have the right to alter or waive the normal provisions of this ***Plan*** when it is reasonable to expect a cost effective result without a sacrifice to the quality of care.

Case Management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that ***covered person*** or any other ***covered person.***

ALTERNATIVE CARE

The ***Utilization Review Organization*** may recommend (or change) alternative methods of medical care or treatment, equipment or supplies that are not ***covered expenses*** under this ***Plan;*** or are ***covered expenses*** under this ***Plan*** but on a basis that differs from the alternative recommended by the ***Utilization Review Organization.*** The ***Plan*** will recognize such alternative services as ***covered expenses.***

Alternative care will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that ***covered person*** or any other ***covered person.***

PREFERRED PROVIDER OR NONPREFERRED PROVIDER

Covered persons have the choice of using either a ***preferred provider*** or a ***nonpreferred provider.***

PREFERRED PROVIDERS

A ***preferred provider*** is a ***physician, hospital*** or ancillary service provider which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a reduced rate for services rendered to ***covered persons.*** This is known as the ***negotiated rate.*** The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate.*** Because the ***covered person*** and the ***Plan*** save money when services, supplies or treatment are obtained from providers participating in the ***Preferred Provider Organization,*** benefits are usually greater than those available when using the services of a ***nonpreferred provider. Covered persons*** should contact the Human Resources Department for a current listing of ***preferred providers.***

Advantages of Using a Preferred Provider

1. The ***covered person*** is not billed for charges that exceed the ***negotiated rate.***

2. The ***covered person*** saves money on health care costs because (A) of the reduced rate (***negotiated rate***) and, (B) the ***Plan*** is able to provide greater benefits from ***preferred providers***.

How to Use the Preferred Providers

1. When the ***covered person*** needs to see the ***physician*** or other health care provider, the directory of ***preferred providers*** will supply a listing of providers in the area. The ***covered person*** should contact the provider to verify the provider is still a member of the ***Preferred Provider Organization.*** It is possible that some providers may have been added to or deleted from the ***Preferred Provider Organization.*** If the provider is still a member, an appointment can be scheduled.

2. Upon arrival for the scheduled appointment, the ***covered person*** should show the ***participating provider*** the identification card. The ***participating provider's*** billing office will submit the claim on behalf of the ***covered person*** to the ***claims administrator***.

3. If additional services from other providers are required, such as diagnostic x-ray and laboratory, the ***covered person*** should ask the ***participating provider*** to ensure such other provider is also a ***participating provider.***

MEDICARE-LIKE RATE PRICING

As permitted under C.F.R. Title 42, Part 136, Subpart D, benefits payable for ***covered expenses*** for ***inpatient*** and ***outpatient hospital*** services which qualify as expenses under the ***Medicare***-Like Rate Program shall be processed at the ***Medicare***-Like Rate pricing or the ***preferred provider negotiated rate,*** whichever is less.

NONPREFERRED PROVIDERS

A ***nonpreferred provider*** does not have an agreement in effect with the ***Preferred Provider Organization.*** This ***Plan*** will allow only the ***customary and reasonable amount*** as a ***covered expense.*** The ***Plan*** will pay its percentage of the ***customary and reasonable amount*** for the ***nonpreferred provider*** services, supplies and treatment. The ***covered person*** is responsible for the remaining balance. This results in greater out-of-pocket expenses to the ***covered person.***

In the event the total charges by a ***nonpreferred provider*** are less than the ***preferred provider negotiated rate,*** or if the ***nonpreferred provider*** agrees to accept less or the equivalent of the ***preferred provider negotiated rate,*** the ***claims***

processor may, in its discretion on behalf of the ***Plan,*** pay the ***nonpreferred provider*** at the ***preferred provider*** level of benefits identified in the section entitled *Schedule of Benefits.*

REFERRALS

Referrals to a ***nonpreferred provider*** are covered as ***nonpreferred provider*** services, supplies and treatments. It is the responsibility of the ***covered person*** to ensure services to be rendered are performed by ***preferred providers*** in order to receive the ***preferred provider*** level of benefits.

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by a ***nonpreferred provider*** where ***covered expenses*** shall be payable at the ***preferred provider*** level of benefits:

1. Radiologist or pathologist services for interpretation of x-rays and laboratory tests rendered by a ***nonpreferred provider*** when the ***facility*** rendering such services is a ***preferred provider.***

2. While confined to a ***preferred provider hospital,*** the ***preferred provider physician*** requests a consultation from a ***nonpreferred provider.***

3. ***Nonpreferred*** anesthesiologist if the operating surgeon is a ***preferred provider.***

4. Diagnostic laboratory and pathology tests referred to a ***nonpreferred provider*** by a ***preferred provider.***

5. If a ***covered person*** is out of the EPO/PPO service are and has a medical ***emergency*** requiring immediate care, including related services such as ancillary providers.

6. ***Medically necessary*** services, supplies and treatments not available through any ***preferred provider.***

MEDICAL EXPENSE BENEFIT

This section describes the ***covered expenses*** of the ***Plan.*** All ***covered expenses*** are subject to applicable ***Plan*** provisions including, but not limited to: deductible, ***copay, coinsurance*** and ***maximum benefit*** provisions as shown in the *Schedule of Benefits*, unless otherwise indicated. Any expenses ***incurred*** by the ***covered person*** for services, supplies or treatment provided will not be considered ***covered expenses*** by this ***Plan*** if they are greater than the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable**.** The ***covered expenses*** for services, supplies or treatment provided must be recommended by a ***physician*** or ***professional provider*** and be ***medically necessary*** care and treatment for the ***illness*** or ***injury*** suffered by the ***covered person.*** Specified preventive care expenses will be covered by this ***Plan.***

COPAY

The ***copay*** is the amount payable by the ***covered person*** for certain services, supplies or treatment**.** The service and applicable ***copay*** are shown on the *Schedule of Benefits.* The ***copay*** must be paid each time a treatment or service is rendered. The ***copay*** will not be applied toward the ***benefit year*** deductible.

DEDUCTIBLES

Preferred Provider Incentive

As an added incentive to utilize ***preferred providers,*** the ***covered person's benefit year*** deductible is less for ***preferred providers*** than the ***benefit year*** deductible of ***nonpreferred providers.*** The individual ***benefit year*** deductible is combined between ***preferred*** and ***nonpreferred providers,*** until the ***preferred provider benefit year*** deductible has been reached. Any additional ***covered expenses*** rendered by a ***nonpreferred provider*** shall be subject to the balance of the ***nonpreferred provider benefit year*** deductible as shown on the *Schedule of Benefits.*

Individual Deductible

The individual deductible is the dollar amount of ***covered expense*** which each ***covered person*** must have ***incurred*** during each ***benefit year*** before the ***Plan*** pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits.*

Family Deductible

If in any ***benefit year*** covered members of a family incur ***covered expenses*** that are subject to the deductible which are equal to or greater than the dollar amount of the family deductible shown on the *Schedule of Benefits,* the family deductible will be considered satisfied for all family members for that ***benefit year***. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

COINSURANCE

The ***Plan*** pays a specified percentage of ***covered expenses*** at the ***customary and reasonable amount*** for ***nonpreferred providers***, or the percentage of the ***negotiated rate*** for ***preferred providers***. That percentage is specified in the *Schedule of Benefits*. The ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the ***negotiated rate*** for ***preferred providers.*** For ***nonpreferred providers***, the ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the billed amount.

BENEFIT YEAR OUT-OF-POCKET EXPENSE LIMIT

Preferred Provider Incentive

As an added incentive to utilize ***preferred providers,*** the ***covered person's*** out-of-pocket expense limit is less for ***preferred providers*** than the out-of-pocket expense limit of ***nonpreferred providers.*** The individual ***benefit year*** out-of-pocket expense limit is combined between ***preferred*** and ***nonpreferred providers,*** until the ***preferred provider*** out-of-pocket expense limit has been reached. Any additional ***covered expenses*** rendered by a ***nonpreferred provider*** shall be subject to the balance of the ***nonpreferred provider benefit year*** out-of-pocket expense limit as shown on the *Schedule of Benefits.*

Individual *Benefit Year* Out-of-Pocket Expense Limit

After the ***covered person*** has incurred an amount equal to the out-of-pocket expense limit listed on the *Schedule of Benefits* for ***covered expenses,*** including ***copays***, the ***Plan*** will begin to pay one hundred percent (100%) for ***covered expenses*** for the remainder of the ***benefit year***.

Family *Benefit Year* Out-of-Pocket Expense Limit

After a covered family has incurred an combined amount equal to the family out-of-pocket expense limit listed on the *Schedule of Benefits* for ***covered expenses,*** including ***copays***, the ***Plan*** will begin to pay one hundred percent (100%) for ***covered expenses*** for all covered family members for the remainder of the ***benefit year***.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the ***benefit year*** out-of-pocket expense limit:

1. Expenses for services, supplies and treatments not covered by this ***Plan,*** to include charges in excess of the ***customary and reasonable amount.***

2. Expense ***incurred*** as a result of failure to obtain precertification.

MAXIMUM BENEFIT

The *Schedule of Benefits* contains separate ***maximum benefit*** limitations for specified conditions. Any separate ***maximum benefit*** will include all such benefits paid by the ***Plan*** for the ***covered person*** during any and all periods of coverage under this ***Plan.***

COVERED EXPENSES

AMBULANCE SERVICES

Ambulance services must be by a licensed air or ground ambulance. ***Covered expenses*** shall include:

1. Ambulance services for air or ground transportation for the ***covered person*** from the place of ***injury*** or serious medical incident to the nearest ***hospital*** where treatment can be given.

2. Ambulance service is covered in a non-emergency situation only to transport the ***covered person*** to or from a ***hospital*** or between ***hospitals*** for required treatment when such treatment is certified by the attending ***physician*** as ***medically necessary.*** Such transportation is covered only from the initial ***hospital*** to the nearest ***hospital*** qualified to render the special treatment.

3. ***Emergency*** services actually provided by an advance life support unit, even though the unit does not provide transportation.

B-12 INJECTIONS

Covered expenses shall include charges for B-12 injections when there is documented deficiency related to malabsorption or impaired utilization and unresolved with oral Vitamin B-12. B-12 therapy is reasonable and necessary when pathologic conditions preclude adequate B-12 absorption from food.

B-12 injections are ***medically necessary*** only for ***covered persons*** with any one of the following diagnoses and conditions:

a. Anemia
- Pernicious anemia (Addision anemia, Biermer's anemia)
- Macrocytic anemia
- Fish tapeworm anemia
- Megaloblastic anemia

b. Gastrointestinal disorders
- Malasorption syndromes such as sprue
- Idiopathic steatorrhea
- Other malabsorption
- Surgical or mechanical disorders such as:
  - resection of the small intestine
  - intestinal strictures
  - intestinal anastomosis
  - blind loop syndrome
  - gastrectomy (subtotal or total)

c. Neuropathy
- Posterolateral sclerosis
- Neuropathies associated with pernicious anemia (Addison anemia, Biermer's anemia)
- Acute phase or acute exacerbation of a neuropathy due to malnutrition or alcoholism

d. Methylamalonic aciduria

e. Homocystinuria

f. Retrobulbar neuritis associated with heavy smoking, also known as tobacco amblyopia

g. Dementia secondary to Vitamin B12 deficiency

h. ***Covered persons*** receiving pemetrexed (Alimta) (see CPB 687)

Physician administration of Vitamin B-12 injections is considered ***medically necessary*** for the diagnoses and conditions listed above.

Administration of Vitamin B-12 injections for more than two (2) to three (3) is subject to review to ascertain if deficiency/abnormalities have improved and to decide whether continued treatment is ***medically necessary.***

Measurement of serum homocystine is considered ***medically*** in persons with borderline B-12 deficiency, where the results will impact the patients management.

BARIATRIC SURGERY

Covered expenses shall include bariatric surgery (restrictive gastrointestinal surgery, adjustable gastric band system sleeve procedures and any other FDA-approved procedure). Such services shall be processed based on clinical criteria and will be considered ***medically necessary*** with documentation of all of the following:

a. The individual is morbidly obese as defined by one (1) of the following:
   - Body Mass Index (BMI) of forty (40) or greater
   - Body Mass Index (BMI) of fifty (50) or greater for biliopancreatic diversion with duodenal switch Procedure
   - Body Index of thirty-five (35) or greater with any of the following co-morbid conditions that are generally expected to be ameliorated (improved), reversed, or limited by this surgical treatment, for any eligible procedure.

b. Co-morbid conditions include, but are not limited to:
   - Cardiovascular disease
   - Coronary disease
   - Degenerative joint disease of weight bearing points
   - Diabetes mellitus
   - Documented sleep apnea
   - Pseudotumor cerebri
   - Pulmonary hypoventilation

c. Diagnosis of morbid obesity for five (5) years or more

d. Continuous participation in a ***physician-***supervised OR structures weight-loss program(s) for six (6) months or longer with a completion date in the preceding year as documented by the following:
   - Weight-loss program(s) in which the individual has participated reflects continuous involvement for a total of six (6) months, or longer and
   - Weight-loss program(s) is a ***physician-***supervised program or a structured weight-loss program (program must be identified and dates of participation must be outlined), and
   - Weight-loss program(s) include a diet and exercise program and/or pharmacological therapy.

e. Failure of non-surgical methods of weight loss as documented by the following:
   - Length of time individual was enrolled or participated in the weight-loss program(s) (program must be identified and dates of participation must be outlined), and
   - Regular follow-up visits documenting program (weekly, monthly) and
   - Results achieved, e.g. weight loss and time to regain the lost weight

f. Pre-operative clinical assessment and documentation must reflect a significant motivation and understanding of the risks associated with the intended surgery, as well as an understanding of the life-long restricted eating habits that will follow.

g. Clinical documentation must reflect a plan for active participation in both a pre-surgical instruction program and a post-surgical, post-operative or follow-up program. Clinical documentation must reflect participation in pre-operative nutritional counseling and that there is a plan in place for post-operative nutritional counseling as well.

h. Individual is eighteen (18) years of age or older.

i. Individual has no treatable condition that may be responsible for the morbid obesity; e.g. endocrine, metabolic, etc.

j. Individual has no significant liver, kidney or gastrointestinal disease.

k. Individual has no drug or alcohol abuse – must be abstinent for twelve (12) months or more if there is a history of drug or alcohol abuse.

l. Individual has no contraindications to surgery.

m. Individual has had an evaluation by a licensed psychologist or psychiatrist documenting the absence of significant psychopathology that may limit an individual's understanding of the procedure or ability to comply with medical/surgical recommendations (e.g. active ***chemical dependency,*** schizophrenia, borderline personality disorder, uncontrolled depression). Clinical documentation must substantiate approval by the attending clinician for the intended procedure if the individual has current symptoms of or is on maintenance for psychological or psychiatric disease.

n. Post-surgery follow-up office visits, related to the approved surgical procedure and outside of the global follow-up period are ***covered expenses,*** subject to the deductible, ***coinsurance*** or ***copay*** provisions.

Repeat bariatric surgeries shall be covered if current ***Plan*** guidelines for bariatric surgery are met.

Revisions to an eligible bariatric surgical procedure are also covered with documentation of any of the following conditions:

a. Anastomosis, leak at site
b. Anastomosis, marginal ulceration at site
c. Band erosion
d. External band slippage
e. Dehiscence/disruption of staple line
f. Disruption of operative wound
g. "Dumping" syndrome, severe
h. Esophageal dilation, symptomatic
i. Esophagitis confirmed on endoscopy or biopsy
j. Failed weight loss with weight regain due to stomal (pouch) dilation
k. Failed weight loss with esophageal dilation
l. Gastroesophageal reflux disease (GERT)
m. Hemorrhage or hematoma complicating a procedure
n. Intractable vomiting
o. Post-gastric surgery syndromes, e.g. post-gastrectomy syndrome, post-vagotomy syndrome
p. Pouch enlargement
q. Stomal stenosis or dilation documented by endscopy
r. Stricture(s) not amenable to balloon dilation
s. Unspecified and other post-surgical non-absorption, e.g. diarrhea following gastrointestinal surgery
t. Weight loss of twenty percent (20%) or more below the ideal body weight (based upon the 1996 Metropolitan Life Height and Weight tables for men/women)

NOTE: Revisions to a prior ineligible or ***investigational*** bariatric surgical procedure are considered a complication of a non-covered service and therefore no covered. Any bariatric surgery requires precertification.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a ***birthing center*** provided the ***physician*** in charge is acting within the scope of his license and the ***birthing center*** meets all legal requirements.

Services of a midwife acting within the scope of his license or registration are a ***covered expense*** provided that the state in which such service is performed has legally recognized midwife delivery.

BOTULINUM TOXIN TYPE A (Botox) AND/OR BOTULINUM TOXIN TYPE B (MYOBLOC)

Covered expenses shall include ***medically necessary*** care, services and treatment for a ***covered person*** receiving Botox therapy with clinical documentation of conditions such as bleparospasm, post-facial (7^{th} cranial) nerve palsy synkinesis hemifacial spasms, laryngeal spasm, focal dystonia, limb spasticity, cervical dystonia, esophageal achalsia and/or

strabismus. Other specific medical conditions may be eligible for treatment when ***medically necessary*** and not excluded by the ***Plan.***

CARDIAC REHABILITATION PROGRAMS

Covered expenses shall include ***medically necessary*** Phase I or II cardiac rehabilitation programs when rendered:

(a) under the supervision of a ***physician;***

(b) in connection with a myocardial infarction, coronary occlusion, or coronary by-pass surgery;

(c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and

(d) in a medical care ***facility*** as defined herein.

CLINICAL TRIALS

Covered expenses for clinical trials shall be limited to a ***covered person*** who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring health care professional is a ***preferred provider*** and has concluded that the ***covered person's*** participation in such trial would be appropriate; or (2) the ***covered person*** provides medical and scientific information establishing that the ***covered person's*** participation in such trial would be appropriate.

Covered expenses shall include routine services, supplies and treatment eligible for coverage under this ***Plan*** that would be required or covered if the ***covered person*** was receiving standard, non-investigational treatment. Such routine services, supplies and treatment include those by a ***physician***, diagnostic or laboratory tests, and other ***covered expenses*** provided during the course of treatment.

CHIROPRACTIC CARE

Covered expense includes services provided by a licensed M.D., D.O. or D.C. for consultation, x-rays and treatment, subject to the ***maximum benefit*** shown on the *Schedule of Benefits.*

COSMETIC SURGERY/RECONSTRUCTIVE SURGERY

Cosmetic surgery or ***reconstructive surgery*** shall be a ***covered expense*** provided:

1. A ***covered person*** receives an ***injury*** as a result of an accident and, as a result, requires surgery. ***Cosmetic surgery*** or ***reconstructive surgery*** and treatment must be for the purpose of restoring the functions of the body which are lost or impaired due to ***injury.***

2. It is required to correct a congenital anomaly, for example, a birth defect.

3. It is required as the result of ***illness*** or previous surgery.

4. It is for reconstructive breast surgery necessary because of a mastectomy. A breast reduction surgery for any other reason is <u>not</u> a ***covered expense.***

5. It is for reconstructive breast reduction on the non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast.

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an ***injury.*** Treatment must begin within ninety (90) days of the date of such ***injury*** and be completed within twelve (12) months after the ***injury.*** Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit. The surgical removal of bony or soft tissue impacted wisdom teeth shall be considered a ***covered expense.***

Subject to precertification, ***covered expenses*** shall include ***medically necessary*** dental restorations directly caused by a medical condition or which are required in order to perform a covered surgery or treatment. Prior to the start of any dental work under this provision, ***covered persons*** must contact the ***Utilization Review Organization*** for authorization and submit a proposed treatment plan to determine whether a dental service shall be deemed ***medically necessary.*** Any treatment not deemed ***medically necessary*** by the ***Utilization Review Organization*** shall not be deemed a ***covered expense.*** Services and treatments specifically excluded under this provision shall include, but are not limited to dental implants and related services; occlusal rehabilitation and reconstructions; orthodontic services; routine dental care; repair and replacement of fixed or removable complete or partial dentures.

DIABETIC SUPPLIES AND EDUCATION

Covered expenses shall include diabetic education and training for ***covered persons*** diagnosed with diabetes to improve self-management. Diabetic education must be prescribed by the patient's ***physician*** as part of a comprehensive plan of care related to diabetes to ensure therapy, compliance, necessary skills and knowledge in the management of diabetes. Training must be done in person. The following diabetic supplies are covered when prescribed by a ***physician*****:**

a. blood glucose monitor (standard model);

b. blood glucose monitor for the legally blind;

c. test strips for glucose monitors and urine test strips;

d. injection aids;

e. syringes and lancets;

f. drawing-up devices and monitors for the visually impaired;

g. any other device, medication, equipment or supply for which coverage is required under ***Medicare,*** when purchased through an eligible ***durable medical equipment*** provider or as specifically listed as covered under the *Prescription Drug Program.*

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging and x-ray.

DURABLE MEDICAL EQUIPMENT

Rental or purchase whichever is less costly of necessary ***durable medical equipment*** and is prescribed by a ***physician*** and required for therapeutic use by the ***covered person*** shall be a ***covered expense.*** Equipment ordered prior to the ***covered person's effective date*** of coverage is not covered, even if delivered after the ***effective date*** of coverage. Repair or replacement of purchased ***durable medical equipment*** which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense.*** Maintenance contracts for purchased equipment will be considered a ***covered expense.***

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the ***covered person's*** condition, or where there exists a reasonably feasible and medically appropriate alternative piece of

equipment which is less costly than the equipment furnished, will be covered based on the usual charge for equipment which would meet the ***covered person's*** medical needs.

EMERGENCY SERVICES/EMERGENCY ROOM

Coverage for emergency room treatment shall be paid in accordance with the *Schedule of Benefits* provided the condition meets the definition of ***emergency*** herein. Emergency room treatment for conditions that do not meet the definition of ***emergency*** or are received subsequent to the initial treatment shall be paid as non-***emergency*** charges. Services of ***nonpreferred providers*** shall be paid at the ***nonpreferred provider*** level.

EXTENDED CARE FACILITY

Extended care facility services, supplies and treatments shall be a ***covered expense*** provided:

1. The ***covered person*** was first confined in a ***hospital***;

2. The attending ***physician*** recommends extended care ***confinement*** for a convalescence from a condition which caused that ***hospital confinement,*** or a related condition;

3. The ***covered person*** is under a ***physician's*** continuous care and the ***physician*** certifies that the ***covered person*** must have twenty-four (24) hours-per-day nursing care and completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge.

Covered expenses shall include:

1. ***Room and board*** (including regular daily services, supplies and treatments furnished by the ***extended care facility)*** limited to the ***facility's*** average ***semiprivate*** room rate; and

2. Other services, supplies and treatment ordered by a ***physician*** and furnished by the ***extended care facility*** for ***inpatient*** medical care.

Extended care facility benefits are limited as shown on the *Schedule of Benefits*.

FACILITY PROVIDERS

Covered expenses shall include services of ***facility*** providers if such services would have been covered if performed in a ***hospital*** or ***ambulatory surgical facility.***

HEARING SERVICES OR DEVICES

Covered expenses shall include charges for hearing aid services, supplies and routine hearing exams, except for hearing screenings included in a routine exam (see *Preventive Care),* including external, semi-implantable middle ear, and implantable bone conduction hearing aids, unless specifically provided herein. Benefits shall be limited as specified on the *Schedule of Benefits.*

HOME HEALTH CARE

Home health care enables the ***covered person*** to receive treatment in his home for an ***illness*** or ***injury*** instead of being confined in a ***hospital*** or ***extended care facility.*** The diagnosis, care and treatment must be certified by the attending ***physician*** and must be contained in a ***home health care*** plan which is reviewed and approved by the patient's ***physician*** at least every thirty (30) days.

Covered expenses shall include:

1. Part-time or intermittent nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse in the patient's home;

2. Services provided on an intermittent basis in the patient's home;

3. Medical supplies including drugs and biological;

4. ***Durable medical equipment;***

5. Enteral nutrition/tube feeding when it is the sole source of nutrition, Nursing visits will only be covered for the purpose of instructing the patient and/or caregiver to initiate and terminate the feeding, unless the patient and/or caregiver cannot perform these tasks, in which case, the visits will be subject to the maximum benefit specified on the *Schedule of Benefits.*

6. Home Infusion/Medication Administration Therapy, including:

   - Intravenous, intramuscular, or subcutaneous administration of medication, except for those injectables specifically listed as covered under the *Prescription Drug Program.*
   - Hydration therapy.
   - Blood/blood components.
   - Total parenteral nutrition.
   - Chemotherapy.
   - Intravenous catheter care.
   - Intravenous antibiotic therapy.

   Growth hormone therapy is covered under the Specialty Pharmacy benefit.

A visit by a member of a ***home health care*** team and (4) hours of ***home health aide service*** will each be considered one (1) ***home health care*** visit. ***Home health*** visits are limited to three (3) per day.

HOSPICE CARE

Hospice care is a health care program providing a coordinated set of services rendered in the patient's or caregiver's home settings for a ***covered person*** suffering from a condition that has a terminal prognosis.

Hospice benefits will be covered only if the ***covered person's*** attending ***physician*** certifies that:

1. The ***covered person*** is terminally ill;

2. The ***covered person*** has a life expectancy of six (6) months or less;

3. A caregiver (family member, friend, or other individual who provides care free of charge) must be available in the home twenty-four (24) hours a day to provide support for the ***covered person's*** daily needs and;

4. The ***covered person*** must meet the requirements of the ***hospice agency.***

Covered expenses shall include:

1. Intermittent services, supplies and treatment provided by a ***hospice*** to a ***covered person*** in a home setting.

2. Respite care, or admission of the patient to an approved facility for up to five (5) days to provide rest for the patient's family or caregiver, limited to once every twenty-one days:

3. Continuous home care, or twenty-four (24) skilled care, provided by a Registered Nurse or Licensed Practical Nurse during a period of crisis, as determined by the ***hospice agency,*** in order to maintain the patient at home,

continuous care is generally delivered in four (4) to eight (8) hours blocks and is limited to seventy-two (72) hours per period of crisis; and

4. ***Inpatient*** acute care for pain control or symptom management that cannot be provided in a home setting.

Charges ***incurred*** during periods of remission are not eligible under this provision of the ***Plan.*** Any ***covered expense*** paid under ***hospice*** benefits will not be considered a ***covered expense*** under any other provision of this ***Plan.***

HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient hospital admissions and ***outpatient*** surgical procedures are subject to precertification. Failure to obtain precertification will result in a reduction of benefits, refer to *Utilization Review.* ***Covered expenses*** shall include:

1. ***Room and board*** for treatment in a ***hospital,*** including ***intensive care units,*** cardiac care units and similar necessary accommodations. ***Covered expenses*** for ***room and board*** shall be limited to the ***hospital's semiprivate*** rate. ***Covered expenses*** for ***intensive care*** or cardiac care units shall be the ***negotiated rate*** for ***preferred providers*** and the ***customary and reasonable amount*** for ***nonpreferred providers.*** In a ***hospital*** having only private rooms, ***covered expenses*** for ***room and board*** shall be limited to the ***hospital's*** standard private room rate. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the ***covered person.***

2. Miscellaneous ***hospital*** services, supplies, and treatments including, but not limited to:
   A. Admission fees, and other fees assessed by the ***hospital*** for rendering ***medically necessary*** services, supplies and treatments;
   B. Use of operating, treatment or delivery rooms;
   C. Anesthesia, anesthesia supplies and its administration by an employee of the ***hospital;***
   D. Medical and surgical dressings and supplies, casts and splints;
   E. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
   F. Drugs and medicines (except drugs not used or consumed in the ***hospital);***
   G. X-ray and diagnostic laboratory procedures and services;
   H. Oxygen and other gas therapy and the administration thereof;
   I. Therapy services.

3. Services, supplies and treatments described above furnished by an ***ambulatory surgical facility,*** including follow-up care provided within seventy-two (72) hours of a procedure.

4. ***Inpatient*** Extended Active Rehabilitation (EAR) services, up to sixty (60) days per calendar year.

5. Preadmission testing (x-rays and lab tests) performed within seven (7) days prior to a ***hospital*** admission which are related to the condition which is necessitating the ***confinement.*** Such tests shall be payable even if they result in additional medical treatment prior to ***confinement*** or if they show that ***hospital confinement*** is not necessary. Such tests shall not be payable if the same tests are performed again after the ***covered person*** has been admitted.

LONG TERM ACUTE CARE (L.T.A.C.)

Covered expenses shall include specialized acute ***hospital*** care for medically complex patients who are critically ill have multi-system complications and/or failures and require hospitalization on an extended basis in a facility offering specialized treatment programs and an aggressive clinical and therapeutic intervention on a 24/7 basis. When ***medical necessity*** criteria for long term acute care are met, benefits are available for no more than a maximum of three hundred sixty-five (365) days while covered by this ***Plan.*** Deductible and ***coinsurance*** provisions apply for each admission. Beds within a facility may be licensed for different levels of care. Even within the same facility, an admission occurs when the patient is moved from a bed licensed for one level of care to a bed licensed for a different level of care.

MASTECTOMY

Covered expense shall include all services, supplies, and treatment of physical complications from all stages of mastectomy, including lymphedemas.

MEDICAL FOODS

Covered expenses shall include medical food used for treatment of metabolic disorders, included in the newborn screening program, including phenylketonuria (PKU), maple syrup urine disease, homocystinuria, and galactosemia. No benefits are payable for foods for any condition not included in the newborn screening program, including lactose intolerance without a diagnosis. To be eligible for medical food benefits, all of the following criteria must be met:

a. the ***covered person*** must be diagnosed with one (1) of the inherited metabolic disorders;

b. the inherited metabolic disorder must involve amino acid, carbohydrate, or fat metabolism and have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine, or spinal fluid or enzyme or DNA confirmation in tissues;

c. the ***covered person*** must require specially processed or treated medical foods generally available only under the supervision of an allopathic or osteopathic ***physician;***

d. the medical foods must be prescribed or ordered under the supervision of allopathic or osteopathic ***physician*** as ***medically necessary*** for the therapeutic treatment of one(1) of the inherited metabolic disorders identified above; and

e. the prescribed or ordered specially processed or treated medical foods must be consumed throughout life, without which, the ***covered person*** may suffer serious mental or physical impairment.

Medical record documentation may be required.

Medical food means modified low protein foods and metabolic formulas that are all of the following:

a. formulated to be consumed or administered through the gastrointestinal tract under the supervision of an allopathic or osteopathic ***physician;***

b. processed or formulated to contain less than one (1) gram of protein per unit of serving (modified low protein foods only);

c. processed or formulated to be defiant in one (1) or more of the nutrients present in typical foodstuffs (metabolic formula only);

d. administered for the medical and nutritional management of a ***covered person*** with limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and

e. essential to the ***covered person's*** optimal growth, health and metabolic homeostasis.

f. Medical foods may be purchased from any source. To receive benefits the ***covered person*** must submit a claim form outlining the following information:
   - the ***covered person's*** name, social security number and group number;
   - the name of the prescribing/ordering ***physician;***
   - the ***covered person*** diagnosis for which the medical foods are prescribed/ordered;
   - where the medical foods were obtained, including the name, address and telephone number of the medical food supplier; and

- the amount paid for the medical food, including the original or copy of the dated receipt/proof of purchase.

MENTAL AND NERVOUS DISORDERS/CHEMICAL DEPENDENCY

Inpatient

Subject to the precertification provisions of the ***Plan,*** the ***Plan*** will pay the applicable ***coinsurance*** for ***confinement*** in a ***hospital*** or ***treatment center*** for services, supplies and treatment related to the treatment of ***mental and nervous disorders/ chemical dependency.***

Covered expenses shall include:

1. ***Inpatient hospital*** confinement;

2. Individual psychotherapy;

3. Group psychotherapy;

4. Psychological testing;

5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same ***professional provider.***

Outpatient

The ***Plan*** will pay the applicable ***coinsurance*** for ***outpatient*** services, supplies and treatment related to the treatment of ***mental and nervous disorders*** or ***chemical dependency.***

Office Visit

The ***Plan*** will pay the applicable ***coinsurance*** for office visits related to the treatment of ***mental and nervous disorders*** and ***chemical dependency.*** ***Covered expenses*** shall include: psychotherapy; therapy services for ***chemical dependency***; diagnostic office visits; office visits for monitoring ***mental and nervous disorders;*** electroconvulsive therapy; and counseling for personal, marriage and family problems. Ten (10) hours of psychological and/or neuropsychological testing per calendar year is covered. The treatment of autism is also a ***covered expense.***

NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

Covered expenses shall include evaluation of mental function when integral to medical care following head trauma, cerebral vascular accident (stroke), transient ischemic attack (TIA) or other decreased mental function related to a documented medical condition, and/or as part of a ***medically necessary*** evaluation of development delay. After the initial evaluation of developmental delay, regardless of the cause of the delay, the only services which are covered for treatment of that condition are physical therapy, occupational therapy and speech therapy.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a ***covered expense***. Orthopedic shoes or corrective shoes, that are an integral part of a leg brace shall be covered. Repair or replacement of an orthotic which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense*** and limited to once while covered by this ***Plan.***

PHYSICIAN SERVICES

Covered expenses shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, ***inpatient*** visits, home visits.

2. Surgical treatment. Separate payment will not be made for ***inpatient*** pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

   If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the ***customary and reasonable amount*** or ***negotiated rate*** that is allowed for the primary procedure; fifty percent (50%) of the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable, will be allowed for each additional procedure performed through the same incision. Any procedure that would be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures.

   If multiple unrelated surgical procedures are performed by two (2) or more surgeons in separate operative fields, benefits will be based on the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable, for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable, allowed for that procedure.

3. Surgical assistance provided by a ***physician*** if it is determined that the condition of the ***covered person*** or the type of surgical procedure requires such assistance

4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.

5. Consultations requested by the attending ***physician*** during a ***hospital confinement.*** The ***Plan*** will pay for one such consultation per ***illness*** or ***injury.*** Consultations do not include staff consultations which are required by a ***hospital's*** rules and regulations.

6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

PODIATRY SERVICES

Covered expenses shall include diagnosis, treatment and prevention of conditions of the feet, including surgical services, incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or débridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

PREGNANCY

Covered expenses for ***pregnancy*** or ***complications of pregnancy*** shall be provided for a covered female ***employee*** or a covered female ***dependent*** of a covered ***employee.***

In the event of early discharge from a ***hospital*** or ***birthing center*** following delivery, the ***Plan*** will cover two (2) Registered Nurse home visits.

The ***Plan*** shall cover services, supplies and treatments for ***medically necessary*** abortions when the life of the mother would be endangered by continuation of the ***pregnancy*** or when the fetus has a known condition which is incompatible with life.

Complications from an abortion for the covered female ***employee*** or a covered ***dependent*** of an ***employee*** shall be a ***covered expense*** whether or not the abortion is a ***covered expense.***

Group health plans 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 forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. If delivery occurs in the ***hospital,*** the 48-hour period, or 96-hours, begins at the time of delivery. If delivery occurs outside the ***hospital*** and is later ***confined*** to the ***hospital*** in connection with childbirth, the period begins at the time of the ***hospital*** admission. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law require that a provider obtain authorization from the ***Plan*** for prescribing a length of stay not in excess of the above periods. If a newborn remains hospitalized beyond the time frames specified above, the ***confinement*** must be precertified.

Benefits shall also be paid for expenses ***incurred*** by the natural birth mother for the birth of any child legally adopted by the ***covered person,*** provided that:

a. the child is adopted within one (1) year from the date the legal adoption process began, and

b. the ***covered person*** is legally obligated to pay the costs of birth, and

c. the ***covered person*** has provided notice to the ***Plan administrator*** within sixty (60) days of their acceptability to adopt children.

PRESCRIPTION DRUGS

The ***Plan*** shall cover prescription drugs which are approved for general use by the Food and Drug Administration and dispensed through a ***physician's*** office or as take-home drugs from a ***hospital.*** The ***covered person*** must be charged for such drugs. If eligible for coverage, such drugs shall be covered under this provision of the ***Plan*** and not under the *Prescription Drug Program.* The prescription drug ***copay*** described in the section, *Prescription Drug Program,* shall apply toward the *Medical Expense Benefit, Out-of-Pocket Expense Limit* for ***preferred providers***.

PREVENTIVE CARE

Covered expenses shall include the preventive services as recommended by the U.S. Preventive Services Task Force:

Preventive Screenings: abdominal aortic aneurysm by ultrasonography in men aged sixty-five (65) to seventy-five (75) who have never smoked; mammograms with or without clinical breast examination as follows: one (1) baseline mammogram for women age thirty-five (35) through thirty-nine (39) and one (1) mammogram every ***benefit year*** for women age forty (40) and over; one (1) cervical cancer screening and pelvic examination; cholesterol abnormalities; colorectal cancer beginning at age fifty (50) and continuing until age seventy-five (75); diabetes; depression; screening for hearing loss in newborn infants; osteoporosis; screening for visual acuity in children younger than age five (5); physical check-up; prostate examination and PSA test; and any related diagnostic x-ray and laboratory.

Immunizations: preventive immunizations from birth for all ***covered persons.***

Pediatric: All preventive Pediatric Health Care as recommended by the Bright Futures project.

Well Woman Preventive Services:

For the purpose of this provision, the term "woman" shall mean a female, age-appropriate ***covered person***. ***Covered expenses*** for Well Woman Preventive Services shall include:

1. Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The frequency is annually, however, the ***Plan*** recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs and other risk factors.
2. Screening for gestational diabetes in pregnant women between ages twenty-four (24) and twenty-eight (28) weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk of diabetes.
3. Human papillomavirus testing DNA testing in women with normal cytology result. Screening should begin at thirty (30) years of age and should occur no more frequently than once every three (3) years.
4. Annual counseling on sexually transmitted infections for all sexually active women.
5. Annual counseling and screening for human immune-deficiency virus infection or all sexually active women.
6. All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.
7. In conjunction with each birth, comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
8. Annual screening and counseling for interpersonal and domestic violence.

PROSTHESIS

The purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) shall be a ***covered expense***. A prosthesis ordered prior to the ***covered person's effective date*** of coverage is not covered, even if delivered after the ***effective date*** of coverage. Repair or replacement of a prosthesis which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense*** and limited to once while covered by this ***Plan.***

External, semi-implantable middle ear, and implantable bone conduction hearing aids shall be a ***covered expense.*** Benefits shall not exceed a maximum of twenty-five thousand dollars ($25,000) (combined with any other hearing device) per ***covered person.***

REHABILITATIVE SERVICES

Rehabilitative services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury,*** for congenital anomaly, or for prevention of continued deterioration of function. ***Covered expenses*** shall include services of a ***professional provider*** for physical therapy, speech therapy, or respiratory therapy, subject to the ***maximum benefits*** specified on the *Schedule of Benefits*. ***Covered expense*** does not include recreational programs.

Inpatient

Inpatient rehabilitative services are subject to precertification. ***Inpatient*** rehabilitative services shall also include room and board, including regular daily services and supplies furnished by the ***facility***, ***physician*** and ***professional providers.***

Outpatient

Outpatient rehabilitative services shall also include daily services and supplies furnished by the ***facility, physician*** and ***professional providers.***

SECOND SURGICAL OPINION

Benefits for a second surgical opinion will be payable for ***physician's*** services if an elective surgical procedure (non-emergency surgery) is recommended by the ***physician***. The ***physician*** rendering the second opinion regarding the ***medical necessity*** of such surgery must be a board certified specialist in the treatment of the ***covered person's illness*** or ***injury*** and must not be affiliated in any way with the ***physician*** who will be performing the actual surgery.

In the event of conflicting opinions, a request for a third opinion may be obtained. The ***Plan*** will consider payment for a third opinion the same as a second surgical opinion.

SLEEP DISORDERS

Obstructive Sleep Apnea Syndrome

a. Obstructive sleep apnea syndrome is considered clinically significant with documentation of the following:
   - Apneic-hypopneic index ((AHI)* of fifteen (15) or more, or
   - AHI between five (5) and fourteen (14) with documentation of any of the following associated symptoms:
     - excessive daytime sleepiness
     - history of stroke
     - hypertension
     - impaired cognition
     - insomnia
     - ischemic heart disease
     - mood disorders

   *The AHI is the average number of episodes of apnea and hypopnea per hour as recorded by a polysomnography based on a minimum of two (2) hours actual sleep. The polysomnography must be performed by a certified sleep laboratory, either in an overnight laboratory or home setting, and reviewed by a certified practitioner and ***professional provider.***

b. The following treatments for clinically significant obstructive sleep apnea syndrome are considered ***medically necessary***:
   - Continuous positive airway pressure (CPAP) for an adult
   - Oral appliance with document of the following:
     - Polysomnography indicates five (5) or more episodes of apnea per hour during sleep, and
     - Obstructive sleep apnea is not of central nervous system (CNS) origin
   - Uvulopalatopharyngoplasty (UPPP) for an individual who has not responded to or cannot tolerate the use of a CPAP device
   - Hyoid suspension, maxillofacial surgery, including mandibular-maxillary advancement or surgical modification of the tongue with documentation of the following:
     - Objective hypopharyngeal obstruction, and
     - Individual has not responded to or cannot tolerate the use of a CPAP device.

c. The following treatments for obstructive sleep apnea syndrome are considered ***investigational*** based upon insufficient scientific evidence to permit conclusion concerning the effect on health outcomes and insufficient evidence to support improvement of the net health outcome:
   - Laser-assisted uvulopalatoplasty (LAUP)
   - Somnoplasty

Upper Airway Resistance Syndrome

a. Upper airway resistance syndrome is considered clinically significant with documentation of ten (10) episodes of EEG arousal per hour of sleep in association with negative intrathoracic pressures. The following treatments for clinically significant upper airway resistance syndrome are considered ***medically necessary:***
   - Continuous positive airway pressure (CPAP) for an adult
   - Uvlopalaropharyngoplasty (UPPP) for an individual who has not responded to or cannot tolerate the use of a CPAP device.

b. The following treatments for upper airway resistance syndrome are considered ***investigational*** based upon insufficient scientific evidence to permit conclusion concerning the effect on health outcomes and insufficient evidence to support improvement of the net health outcome:
   - Laser-assisted uvulopalatoplasty (LAUP)

- Somnoplasty

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include ***medically necessary*** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; disposable supplies required to operate or maintain a covered prosthesis or ***durable medical equipment;*** catheters; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof, including rental charges for thirty-six (36) months. Beginning six (6) months after the thirty-six (36) month rental period ends, maintenance visits are covered every six (6) months for two (2) years at which time the concentrator will be deemed to have met its reasonable lifetime use and the billing cycle will start again if the patient still needs oxygen; intravenous injections and solutions and their administration; the purchase of one (1) wig per calendar year for the diagnosis of alopecia resulting from ***illness*** *or* ***injury;*** blood and blood components and derivatives that are not donated or replaced; the initial pair of eyeglasses or contact lenses due to cataract surgery subject to the ***maximum benefit*** specified on the *Schedule of Benefits* and prescribed within six (6) months following surgery; soft lenses or sclera shells intended for use in the treatment of ***illness*** or ***injury*** of the eye; surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

STERILIZATION

Covered expenses shall include elective sterilization procedures for the covered ***employee*** or covered spouse. Reversal of sterilization is not a ***covered expense.***

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Surgical and nonsurgical treatment of temporomandibular joint (TMJ), myofacial pain syndrome or non-surgical orthognathic treatment shall be a ***covered expense,*** but shall not include orthodontia or prosthetic devices prescribed by a ***physician*** or ***dentist***. The ***maximum benefit*** payable for diagnosis and treatment of TMJ, myofacial pain syndrome or orthognathic disorders per ***covered person*** is shown in the *Schedule of Benefits.* This limitation shall apply whether treatment is provided by a ***hospital, physician, dentist,*** physical therapist or oral surgeon.

THERAPY SERVICES

Covered expenses shall include the ***facility*** and services of a ***professional provider*** for x-ray, radium or radiotherapy treatment; chemotherapy; dialysis therapy or treatment; and IV infusion therapy, whether rendered on an ***inpatient*** or ***outpatient*** basis. The services of technicians are included. Chemotherapy and infusions must be precertified, regardless of the place of service. Failure to obtain precertification shall result in a reduction in benefits.

TRANSPLANT

Services, supplies and treatments in connection with the listed human-to-human organ and tissue transplant procedures will be considered ***covered expenses*** subject to the following conditions:

1. When the recipient is covered under this ***Plan,*** the ***Plan*** will pay the recipient's ***covered expenses*** related to the transplant.

2. When both the donor and recipient are covered under this ***Plan,*** the ***Plan*** will pay the donor's ***covered expenses*** related to the transplant, will be processed under the recipient’s benefit.

3. Expenses ***incurred*** by the donor who is not ordinarily covered under this ***Plan*** according to *Eligibility* requirements will be ***covered expenses*** to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, within six (6) months following the transplant and provided the recipient is covered under this ***Plan.***

4. Surgical, storage and transportation costs directly related to procurement and transplant of an organ or tissue used in transplant procedure will be covered for each procedure completed if the donor or recipient lives more than seventy-five (75) from the transplant site. Such charges do not count for the initial transplant evaluation but will count charges for treatment of complications or for routine transplant follow-up. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a ***covered expense*** under this ***Plan.***

5. Marrow search and procurement when the ***covered person*** is the recipient of a covered allogenic transplant.

6. Air and ground transportation of a medical team to and from the transplant site in the U.S. for the procurement of an organ or tissue that is subsequently transplanted.

If a ***covered person's*** transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

The following are covered transplant procedures:

1. Organ transplants, including heart, heart/lung (lobar, single and double lung), kidney, pancreas, kidney/pancreas and liver.

2. Small bowel, small bowel-multivisceral.

3. Corneal transplants.

4. Autologous islet transplantation (AECT).

5. Allogenic, autologous and/or syngenic bone marrow transplants.

Benefits for allogenic, autologous and/or syngenic bone marrow transplants (including peripheral stem cell rescue (PSCR) procedures and/or HDC or HDR are not available for treatment of all conditions or all stages of a condition, even is a provider recommends such treatment.

WELL NEWBORN CARE

The ***Plan*** shall cover well newborn care (including circumcision) while the mother is confined for delivery. ***Covered expenses*** for services, supplies or treatment of the newborn child shall be considered charges of the child and as such, subject to a separate deductible (if applicable), ***copay*** and ***coinsurance*** from the mother.

MEDICAL EXCLUSIONS

In addition to *Plan Exclusions*, no benefit will be provided under this ***Plan*** for medical expenses for the following:

1. Charges for services, supplies or treatment for the reversal of sterilization procedures.

2. Charges for services, supplies or treatment related to the diagnosis or treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation, or gamete intrafallopian transfer (GIFT).

3. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

4. Charges for treatment or surgery for sexual dysfunction.

5. Charges for ***hospital*** admission on Friday, Saturday or Sunday unless the admission is an ***emergency*** situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, ***hospital*** expenses will be payable commencing on the date of actual surgery.

6. Charges for ***inpatient room and board*** in connection with a ***hospital confinement*** primarily for diagnostic tests or therapy, unless it is determined by the ***Plan*** that ***inpatient*** care is ***medically necessary.***

7. Charges for biofeedback therapy.

8. Charges for services, supplies or treatments which are primarily educational in nature, except as specified in *Medical Expense Benefit, Patient Education and Preventive Care;* charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

9. Except as specifically stated in *Medical Expense Benefit, Dental Services*, charges for or in connection with: treatment of ***injury*** or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

10. Except as specified in *Preventive Care,* charges for routine vision examinations and eye refractions; orthoptics; eyeglasses or contact lenses, except as specifically stated under *Special Equipment and Supplies*; dispensing optician's services.

11. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.

12. Except as ***medically necessary*** for the treatment of diabetes, neurological involvement or peripheral-vascular ***illness,*** charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

13. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a ***physician,*** such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment or other items considered "luxury medical equipment", such as, motorized wheelchairs or other vehicles, bionic or computerized artificial limbs

14. Except as mandated by Healthcare Reform, charges for nonprescription drugs, such as vitamins (except prenatal vitamins), cosmetic dietary aids, and nutritional supplements, except as specified herein.

15. Expenses for a ***cosmetic surgery*** or ***cosmetic treatment*** and all related services, except as specifically stated in *Medical Expense Benefit, Cosmetic Surgery.*

16. Charges ***incurred*** as a result of, or in connection with, ***cosmetic surgery*** or any procedure or treatment excluded by this ***Plan*** which has resulted in medical complications, except for complications from a non-covered abortion.

17. Charges for services provided to a ***covered person*** for an elective abortion. However, complications from such procedure shall be a ***covered expense.*** Refer to *Medical Expense Benefit, Pregnancy* for ***Plan's*** coverage of non-elective abortions.

18. Except as specified in *Preventive Care,* charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of a treatment plan for another ***illness;*** however, ***medically necessary*** charges for bariatric surgery, as specified in *Bariatric Surgery* will be covered.

19. Except a specified in *Preventive Care,* a charge for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches.

20. Except as specified in *Preventive Care* or *Hearing Services or Devices,* charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid; or charges for a cochlear implant.

21. Charges related to acupuncture or acupressure treatment.

22. Charges for ***custodial care,*** domiciliary care or rest cures.

23. Charges for travel, meals or accommodations, whether or not recommended by a ***physician,*** except as specifically provided herein.

24. Except as specified in *Special Equipment and Supplies,* charges for wigs, artificial hair pieces, artificial hair transplants, or any drug - prescription or otherwise -used to eliminate baldness or promote hair growth.

25. Charges for expenses related to hypnosis.

26. Charges for prescription drugs that are covered under the *Prescription Drug Program.*

27. Charges for any services, supplies or treatment not specifically provided herein.

28. Charges for professional services billed by a ***physician*** or Registered Nurse, Licensed Practical Nurse or Licensed Vocational Nurse who is an employee of a ***hospital*** or any other ***facility*** and who is paid by the ***hospital*** or other ***facility*** for the service provided.

29. Charges for environmental change including ***hospitalization*** or ***physician*** charges connected with prescribing an environmental change.

30. Charges for ***room and board*** in a ***facility*** for days on which the ***covered person*** is permitted to leave (a weekend pass, for example.)

31. Charges for replacement braces of the leg, arm, back, neck or artificial arms or legs, unless there is sufficient change in the ***covered person's*** physical condition to make the original device no longer functional.

32. Charges for activity therapy, milieu therapy or any care primarily intended to assist an individual in the activities of daily living or for the comfort or convenience of the patient or family member except for limited ***hospice*** benefits as specified herein.

33. Charges for non-traditional or alternative medical therapies, e.g. interventions, services or procedures not commonly accepted as part of allogenic or osteopathic practices, naturopathic and homeopathic medicine, diet therapies, nutritional or lifestyle therapies and aromatherapy.

34. Charges for a ***covered person*** receiving Botox therapy, regardless of ***medical necessity*** and/or recommendation by a ***professional provider*** for any of the following reasons:
    a. Headache, including cerviogenic, cluster, migraine or tension headache; or
    b. Fibromyositis; or
    c. Painful cramps; or
    d. Anal sphincter dysfunction; or
    e. Lower urinary tract dysfunction (e.g. detrusor overactivity/overactive bladed and detrusor-sphincter dyssynergia); or
    f. Bell's palsy; or
    g. Stuttering; or
    h. Irritable colon; or
    i. Biliary dyskinesia; or
    j. Temporomandibular joint disorders; or
    k. Chronic low back pain; or
    l. Chronic neck pain; or
    m. Gastroparesis; or
    n. Clubfoot; or
    o. Cranial/facial pain of unknown etiology; or
    p. Piriformis syndrome; or
    q. Pylorospasm; or
    r. Chronic constipation; or
    s. Wrinkles, frown lines; or
    t. Aging neck; or
    u. Blepharoplasty (eye lids).

35. Charges for services related to improving cognitive functioning (i.e. higher brain functions), reinforcing or re-establishing previously learned thought processes, compensary training, sensory integrative activities, or services related to employability.

36. Charges for complications of body piercing, implants (body art) and/or tattooing, e.g. the evaluation, treatment, removal, and/or lacerations, infections, cellulites and keloids.

37. Charges for counseling in the absence of ***illness*** or ***injury,*** including, but not limited to, marital, education, social, behavior modification services, or recreational therapy; or counseling with the patient's friends, employer, school counselor or school teacher.

38. Charges for court-ordered testing, treatment or therapy, unless such services are otherwise covered under this ***Plan.***

39. Charges for all dietary, caloric and nutritional supplements, e.g. specialized formulas for infants, children or adults or other special foods or diets, even if prescribed by a ***professional provider,*** except as specified in *Medical Foods.*

40. Charges for repair costs that exceed the replacement cost of an item; repair or replacement costs that are lost or damaged due to neglect or use not recommended by the manufacturer; medical equipment and/or supplies that can be purchased over the counter; items primarily for personal comfort, convenience or assistance in daily living; supplies used by a provider during office treatments; artificial organs determined to be ***experimental/investigational.***

41. Charges for services related to a surrogate ***pregnancy.***

42. No benefits are payable for medical foods for the following: foods for any conditions other than those inherited metabolic disorders as specified in *Medical Foods;* natural foods that are naturally low in protein and/or glactose; spices or flavorings; foods/flavorings available to any person, even those without inherited metabolic disorders that may be purchased without a prescription or that do not require supervision by an allopathic or osteopathic provider.

43. Charges for prescription medications and over-the-counters, including pharmaceutical manufacturer's samples, dispensed to the patient in the office by any mode of administration. This does not include eligible injectable drugs administered in the provider's office. Such eligible drugs must be obtained through the Specialty Pharmacy Program.

44. Charges for ***outpatient*** therapy, ***outpatient*** cardiac rehabilitation and ***inpatient*** extended active rehabilitation for these items: cognitive therapy; services rendered after a patient has met functional goals and no objectively measurement improvement is reasonably expected, custodial therapy, massage therapy or computer speech training/therapy programs or devices.

45. Charges for routine care or services not directly related to an ***illness*** or ***injury,*** except as specified in *Preventive Care.*

46. Charges for screening and/or diagnostic testing or treatment without a personal history of a specific diagnosis, except as specified in *Preventive Care.*

47. Charges for high-dose chemotherapy, high dose radiation or other services administered with a non-covered transplant.

48. Charges for transportation or travel expenses, except as specified

PRESCRIPTION DRUG PROGRAM

The ***employer*** has contracted with a nationwide network of ***participating pharmacies*** to provide prescription drugs and medicines at a reduced rate to ***covered persons. Covered expenses,*** limitations and exclusions for prescription drugs are determined through the referenced contract. The Prescription Drug Program described herein is a separate benefit from the Medical Expense Benefit of the ***Plan.*** However, benefits of the Prescription Drug Program are subject to the ***maximum benefit*** while covered by this ***Plan*** as shown on the *Schedule of Benefits, Medical Benefits.*

The prescription drug ***copays*** will apply to the *Medical Expense Benefit* ***preferred provider*** out-of-pocket expense limit. Once the ***benefit year preferred provider*** out-of-pocket expense limit has been reached, the ***Plan*** will pay for ***covered persons*** covered prescription drugs at 100% for the remainder of the ***benefit year.***

There are two (2) aspects of the Prescription Drug Program.

PHARMACY OPTION

Participating pharmacies have contracted with the ***Plan*** to charge ***covered persons*** reduced fees for covered prescription drugs.

The ***copay*** is applied to each covered pharmacy drug and is shown on the S*chedule of Benefits*. Any one prescription is limited to a thirty (30) day supply.

If a drug is purchased from a ***nonparticipating pharmacy*** or a ***participating pharmacy*** when the ***covered person's*** ID card is not used, the ***covered person*** must pay the entire cost of the prescription. No benefits are payable under this ***Plan.***

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer ***covered persons*** significant savings on prescriptions.

The ***copay*** is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits.* Any one prescription is limited to a ninety (90) day supply.

PRIOR AUTHORIZATION

Certain categories of medication require prior authorization from the Pharmacy Benefit Manager. These categories include, but are not limited to:

1. Acne Medication – Acne medications with Tretionin agents are covered for those under age twenty-four then require prior authorization.

2. Anti-Fungual.

3. Migraine Medications.

4. Certain Injectable Drugs.

COVERED PRESCRIPTION DRUGS

1. All drugs prescribed by a ***physician*** that require a prescription either by federal or state law, except insulin and drugs excluded by the ***Plan.***

2. All compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Diabetic supplies when prescribed by a ***physician.***

4. Contraceptives.

5. Over-the counter medications as mandated by Healthcare Reform.

For a complete listing of covered prescription drugs, refer to the Pharmacy Benefit Management contract.

LIMITS TO THIS BENEFIT

This benefit applies only when a ***covered person incurs*** a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a ***physician.***

2. Refills up to one year from the date of order by a ***physician.***

PRESCRIPTION EXCLUSIONS

In addition to the *Plan Exclusions,* no prescription benefit shall be payable for the following:

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin, or over the counter medications which can be purchased as specifically stated herein.

2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, glucose monitors, braces, support garments, or any similar device.

3. Immunization agents or biological sera.

4. A drug or medicine labeled: “Caution - limited by federal law to investigational use.”

5. Experimental drugs and medicines, even though a charge is made to the ***covered person*** including DESI drugs (drugs determined by the FDA as lacking substantial evidence of effectiveness.)

6. Any charge for the administration of a covered prescription drug.

7. Any drug or medicine that is consumed or administered at the place where it is dispensed, except as mandated by Healthcare Reform.

8. A drug or medicine that is to be taken by the ***covered person***, in whole or in part, while ***hospital confined.*** This includes being confined in any institution that has a facility for dispensing drugs.

9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.

10. A charge for fertility or infertility medication.

11. A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or diabetic supplies. Certain medical foods are covered under the *Medical Expense Benefit.*

12. A charge for any drug not approved by the Food and Drug Administration (FDA).

13. A charge for impotence medications or to treat sexual dysfunction.

14. A charge for performance, athletic performance or lifestyle enhancement drugs or supplies).

15. A charge for prescriptions or refills for drugs that are lost, stolen, spilled, spoiled or damaged,

16. A charge for drug delivery implants.

17. A charge for any prescription drug dispensed in unit-dose packaging unless that is the only form in which the drug is available.

For a complete listing of prescription exclusions, refer to the Pharmacy Benefit Management contract.

PLAN EXCLUSIONS

The ***Plan*** will not provide benefits for any of the items listed in this section, regardless of ***medical necessity*** or recommendation of a ***physician*** or ***professional provider.***

1. Charges for services, supplies or treatment from any ***hospital*** owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.

2. Charges for an ***injury*** sustained or ***illness*** contracted while on active duty in military service, unless payment is legally required.

3. Charges for services, supplies or treatment for treatment of ***illness*** or ***injury*** which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

4. Any condition for which benefits of any nature are recovered or are found to be recoverable, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the ***covered person*** fails to claim rights to such benefits or fails to enroll or purchase such coverage.

5. Charges in connection with any ***illness*** or ***injury*** arising out of or in the course of any employment intended for wage or profit, including self-employment.

6. Charges made for services, supplies and treatment which are not ***medically necessary*** for the treatment of ***illness*** or ***injury,*** or which are not recommended and approved by the attending ***physician,*** except as specifically stated herein, or to the extent that the charges exceed the ***customary and reasonable amount,*** exceed the ***negotiated rate*** or ***Medicare*** – like rate, as applicable.

7. Charges in connection with any ***illness*** or ***injury*** of the ***covered person*** resulting from or occurring during the ***covered person's*** commission or attempted commission of a criminal battery or felony. Claims shall be denied if the ***Plan administrator*** has reason to believe, based on objective evidence such as police reports or medical records, that a criminal battery or felony was committed by the ***covered person.***

8. To the extent that payment under this ***Plan*** is prohibited by any law of any jurisdiction in which the ***covered person*** resides at the time the expense is ***incurred.***

9. Charges for services rendered and/or supplies received prior to the ***effective date*** or after the termination date of a person's coverage.

10. Any services, supplies or treatment for which the ***covered person*** is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

11. Charges for services, supplies or treatment that is considered ***experimental/investigational,*** except as specified herein***.***

12. Charges for services, supplies or treatment rendered by any individual who is a ***close relative*** of the ***covered person*** or who resides in the same household as the ***covered person.***

13. Charges for services, supplies or treatment rendered by physicians or ***professional providers*** beyond the scope of their license; for any treatment, ***confinement*** or service which is not recommended by or performed by an appropriate ***professional provider.***

14. Charges for ***illnesses*** or ***injuries*** suffered by a ***covered person*** due to the action or inaction of any party if the ***covered person*** fails to provide information as specified in *Subrogation/Reimbursement.*

15. Claims not submitted within the ***Plan's*** filing limit deadlines as specified in *Claim Filing Procedures.*

16. Charges for e-mail, internet or telephone consultations, completion of claim forms, charges associated with missed appointments.

17. Charges for services, supplies or treatment for ***covered persons*** who are Native American which are rendered by Indian Health Services or Contract Health Services, or for any charges for services, supplies, or treatment rendered by any other health care provider wherein Indian Health Services/Contract Health Services made a referral for such.

18. Charges for services, supplies, care or treatment to a ***covered person*** for an ***injury*** which occurred as a result of that ***covered person's*** illegal use of alcohol. Claims shall be denied if the ***Plan administrator*** has reason to believe, based on objective evidence such as police reports or medical records of the ***covered person's*** illegal use of alcohol. Expenses will be covered for injured ***covered persons*** other than the person illegally using alcohol and expenses will be covered for ***chemical dependency*** treatment as specified on the *Schedule of Benefits*. This exclusion does not apply if the ***injury*** resulted from an act of domestic violence or an underlying medical condition.

19. Charges for services, supplies, care or treatment to a ***covered person*** for ***injury*** resulting from that ***covered persons*** voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a ***physician.*** Expenses will be covered for injured ***covered persons*** other than the person using controlled substances and expenses will be covered for ***chemical dependency*** as specified herein.

20. Charges for care and treatment of an ***injury*** or ***illness*** that results from activity where the ***covered person*** is found by a court of competent jurisdiction and/or a jury of his/her peers to have been negligent in his/her actions, as "negligence" is defined by the jurisdiction where the activity occurred,

21. Charges ***incurred*** outside the United States if the ***covered person*** traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

ELIGIBILITY

This section identifies the ***Plan's*** requirements for a person to be eligible to enroll for coverage under this ***Plan.*** Refer to the sections entitled, *Enrollment,* and *Effective Date of Coverage* for more information about the ***Plan's*** requirements for coverage hereunder.

The ***employer*** engages the use of ***measurement periods*** for tracking an ***employee's hours of service.*** If during a ***measurement period,*** the ***employee*** averages thirty (30) ***hours of service*** per ***week,*** the ***employee*** will be deemed eligible to enroll for coverage under this ***Plan*** as a ***full-time, regular employee.*** For the purpose of the following provisions on ***employee*** eligibility under the terms of the ***Plan,*** whether an ***employee*** averages thirty (30) ***hours of service*** per ***week*** will be determined in accordance with the policies and procedures adopted by the ***employer*** which are determined in a manner consistent with the Internal Revenue Code Section 4980H and the regulations issued thereunder.

The ***employer*** has the option of engaging a "Monthly***" measurement period*** for some ***employee*** classifications, and the "Look Back" ***measurement period*** for other ***employee*** classifications:

1. The "Monthly" ***measurement period*** is for those ***employees*** who are reasonably determined at the time of hire to be a ***full-time, regular employee.***

2. The "Look Back" ***measurement period*** is for those ***employees*** whose ***hours of service*** cannot be categorized as ***full-time, regular*** and are generally placed in the "Look Back" ***measurement period*** method***.*** The Look Back ***measurement period*** method consists of three components:

   A. A ***measurement period*** shall be for the purpose of tracking an ***employee's hours of service*** during the ***measurement period;***

   B. The ***administrative period*** shall be for the purpose of assessing an ***employee's*** eligibility for coverage under the ***Plan,*** prepare and distribute enrollment materials, and allow time for ***employee*** submission of properly completed application for enrollment by the end of the ***administrative period.***

   C. The ***stability period*** shall be for the purpose of establishing the period of time the eligible, enrolled ***employee*** shall remain on the ***Plan*** if the ***employee*** met the eligibility criteria during the ***measurement period***, subject to any ***break in service***, and *Termination of Coverage* provisions of the ***Plan.***

   After the ***initial measurement period***, the ***stability period*** and the ***standard measurement period*** overlap on the time line.

EMPLOYEE ELIGIBILITY

NEW HIRES

For Full-time, Regular Employees on the Monthly Measurement or Look Back Measurement Period Method:

All ***full-time*** or ***part-time employees*** working at least thirty (30) hours per week shall be eligible to enroll for coverage under this ***Plan.*** This does not include temporary ***employees.***

For Qualifying Part-time Employees on the Look Back Measurement Period Method:

Any other ***employees,*** including, but not limited to, ***seasonal employees***, who are not ***full-time, regular employees*** to the extent that such ***employees*** average thirty (30) ***hours of service*** per ***week*** over the ***employee's*** applicable ***initial measurement period***, shall be eligible to enroll for coverage under this ***Plan*** during the applicable ***administrative period.***

If a ***qualifying part-time employee*** transfers to a ***full-time, regular employee*** position prior to the start of the ***qualifying part-time employee's new employee stability period,*** the ***employee*** will become eligible for coverage as a ***full-time, regular employee.***

FOR ONGOING EMPLOYEES ON THE LOOK BACK MEASUREMENT PERIOD METHOD

Once an ***employee*** has completed the ***standard measurement period,*** eligibility will be based solely on the ***employee's hours of service*** during the ***standard measurement period.*** Any ***employee*** who averages thirty (30) ***hours of service*** per ***week*** during the ***standard measurement period (ongoing employees)*** will be eligible for coverage under the ***Plan*** during the next ***ongoing employee stability period*** to the extent that the ***ongoing employee*** remains employed, subject to the ***Plan's break in service*** rules, and *Termination of Coverage* provisions of the ***Plan.***

BREAK IN SERVICE RULES

1. If the ***employee*** experiences a ***break in service*** during a ***measurement period*** and then again resumes ***hours of service,*** such ***employee*** will be treated as a New Hire ***employee*** upon the date that the ***employee*** resumes ***hours of service*** for the ***employer.***

2. If during an ***ongoing employee stability period,*** the ***employee*** experiences a period without any ***hours of service,*** and subsequently resumes ***hours of service*** but does not experience a ***break in service***, the ***employee*** will be treated as a continuous ***employee.*** Such an ***employee*** will be eligible for coverage under the ***Plan*** upon return to work if they were enrolled in coverage prior to the start of the period with no ***hours of service***.

   Such coverage will be effective on the first day of month that coincides with or follows the date the ***employee*** resumes ***hours of service,*** provided the ***employee*** submits the completed application for enrollment to the ***employer*** within thirty (30) days of resuming ***full-time*** status.

   Prior benefit accumulators shall apply as though there was no break in coverage for any ***employee*** that experiences a ***break in service*** and then returns to coverage under the ***Plan.***

3. Impact of ***special unpaid leaves of absence***: If the ***employee*** takes a ***special unpaid leave of absence*** during a ***measurement period***, the ***employer*** will disregard all consecutive ***weeks*** of such unpaid leave when determining the average ***hours of service*** during the applicable ***measurement period.***

ADDITIONAL TERMS OF ELIGIBILITY FOR QUALIFYING PART-TIME EMPLOYEES AND ONGOING EMPLOYEES ON THE LOOK BACK MEASUREMENT PERIOD METHOD

The ***employer*** will determine a ***qualifying part-time employee's*** and an ***ongoing employee's*** eligibility for coverage under the ***Plan*** in accordance with the following requirements:

1. An ***employee's hours of service*** during the applicable ***measurement period*** will be considered in determining eligibility for coverage under the ***Plan*** to the extent not preceded by a ***break in service.***

2. Impact on Payroll Periods: For payroll periods that are one ***week***, two ***weeks,*** or semi-monthly in duration, the ***employer*** is permitted to treat as a ***measurement period*** a period that ends on the last day of the payroll period preceding the payroll period that includes the date that would otherwise be the last day of the ***measurement period***, provided that the ***measurement period*** begins on the first day of the payroll period that includes the date that would otherwise be the first day of the ***measurement period***.

   The ***employer*** may also treat as a ***measurement period,*** a period that begins on the first day of the payroll period that follows the payroll period that includes the date that would otherwise be the first day of the ***measurement period,*** provided that the ***measurement period*** ends on the last day of the payroll period that includes the date that would otherwise be the last day of the ***measurement period***.

DEPENDENT(S) ELIGIBILITY

The following describes ***dependent*** eligibility requirements. The ***employer*** will require proof of ***dependent*** status.

1. The term "spouse" means the spouse of the ***employee*** under a legally valid existing marriage in the state in which the ***employee*** resides, unless court ordered separation exists. The term spouse does not include an ***employee's*** domestic partner or common-law spouse.

2. The term "child" means the ***employee's*** natural child, stepchild, legally adopted child, foster child that is placed with the ***employee*** by an authorized agency or court of law, and a child for whom the ***employee*** has been appointed legal guardian, either temporary or permanent, by a court of law, prior to age eighteen (18), provided the child has not reached the end of the month of his or her twenty-sixth (26th) birthday.

3. An eligible child shall also include any other child of an ***employee*** or their spouse who is recognized in a qualified medical child support order (QMCSO), which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan,*** even if the child is not residing in the ***employee's*** household. Such child shall be referred to as an ***alternate recipient***. ***Alternate recipients*** are eligible for coverage regardless of whether the ***employee*** elects coverage for himself. An application for enrollment must be submitted to the ***employer*** for coverage under this ***Plan.*** The ***employer/Plan administrator*** shall establish written procedures for determining whether a medical child support order is a QMCSO and for administering the provision of benefits under the ***Plan*** pursuant to a valid QMCSO. The ***employer/Plan administrator*** reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency. ***Employees*** and ***dependents*** may obtain, without charge, a copy of the ***employer's*** procedures governing qualified medical child support orders (QMCSO).

4. Adopted children, who are less than eighteen (18) years of age at the time of adoption, shall be considered eligible from the date the child is ***placed for adoption.*** ***"Placed for adoption"*** means the date the ***employee*** assumes legal obligation for the total or partial financial support of the child during the adoption process.

5. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the ***employee*** for support due to a mental and/or physical disability, and who was covered under the ***Plan*** prior to reaching the maximum age limit or other loss of ***dependent's*** eligibility, will remain eligible for coverage under this ***Plan*** beyond the date coverage would otherwise be lost.

   Proof of incapacitation must be provided within thirty (30) days of the child's loss of eligibility and thereafter as requested by the ***employer*** or ***claims processor,*** but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

   A. Cessation of the mental and/or physical disability;

   B. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Eligible ***dependents*** do not include:

1. Other individuals living in the covered ***employee's*** home, but who are not eligible as defined.

2. The legally divorced former spouse of the ***employee.***

3. Any person who is considered a domestic spouse or common-law spouse.

4. Any person who is on active duty in any military service of any country, unless otherwise specified herein.

5. Any person who is covered under the ***Plan*** as an ***employee***.

ENROLLMENT

The benefits of this ***Plan*** are based on a ***benefit year.*** If an ***employee*** or ***dependent*** enrolls for coverage at any time during the ***benefit year,*** the benefits will be calculated on a ***benefit year.***

APPLICATION FOR ENROLLMENT

NEW HIRES

Full-time, Regular Employee on the Monthly Measurement or Look Back Measurement Period Method

A ***full-time, regular employee*** must file a written application with the ***employer*** for coverage hereunder for himself and his eligible ***dependents*** within thirty (30) days of the date coverage would otherwise be effective. Refer to the section entitled, *Effective Date of Coverage.* The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder.

Qualifying Part-time Employee on the Look Back Measurement Period Method

An ***employee*** who has completed the ***initial measurement period*** and during the ***administrative period***, the ***employer*** deems the ***employee*** to have met the eligibility requirements of the ***Plan***, the ***qualifying part-time employee*** must file a written application with the ***employer*** for coverage hereunder for himself and his eligible ***dependents*** during the ***administrative period.*** The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder prior to the end of the ***administrative period.***

FOR ONGOING EMPLOYEES ON THE LOOK BACK MEASUREMENT PERIOD METHOD

Ongoing employees who have completed their ***standard measurement period*** and during the ***administrative period,*** the ***employer*** deems the ***employee*** to have met the eligibility requirements of the ***Plan,*** may elect coverage for himself and any eligible ***dependents*** if he is not covered under the ***Plan,*** or may change benefit plan options for himself or any enrolled ***dependents*** during the ***administrative period***. Enrolled ***employees*** may add or drop coverage for themselves or for enrolled ***dependents*** during the ***administrative period.*** The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder prior to the end of the ***administrative period.***

EMPLOYEE RESPONSIBILITY FOR ENROLLMENT

Employees deemed eligible to enroll for coverage under this ***Plan*** shall bear the responsibility of submitting a properly completed application for enrollment to the ***employer*** within the timeline as determined by the ***Plan.*** The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder.

If the ***employee*** acquires a ***dependent*** after submitting the application for enrollment to the ***employer*** and wishes to enroll the eligible ***dependents,*** the ***employee*** shall submit a revised application for enrollment to the ***employer*** within thirty (30) days of marriage, or the acquiring of children, or birth of a child. The ***employer*** must be notified of any change in a ***dependent's*** loss of eligibility within thirty (30) days of the change***,*** including divorce or legal separation, death, child's reaching the maximum age for eligibility under this ***Plan.*** Forms are available from the ***employer*** for reporting changes in ***dependents'*** eligibility as required.

Once a properly completed application for enrollment has been submitted to the ***employer*** and coverage has become effective, as defined in the section entitled, *Effective Date of Coverage,* the ***employee's*** enrollment option shall remain in effect. The only opportunity to change the enrollment option shall be during the ***administrative period*** for those ***employees*** under the look back ***measurement period*** method; or during the open enrollment for those ***employees*** under the monthly ***measurement period*** method***;*** or upon a Special Enrollment option as defined below. A written waiver of

coverage stating the existence of coverage under another ***creditable coverage*** must have been completed by the ***employee*** in order for the ***employee*** to be considered a Special Enrollee at a later date.

Failure to complete the application for enrollment within thirty (30) days shall result in the *Late Enrollment* provision applying to the individual. An ***alternate recipient*** can be enrolled in the ***Plan*** at any time and shall not be subject to the *Late Enrollment* provision.

EMPLOYEE/SPOUSE ENROLLMENT

Every eligible ***employee*** may enroll eligible ***dependents.*** However, if both the husband and wife are ***employees,*** each individual will be covered as an ***employee.*** An ***employee*** cannot be covered as an ***employee*** and a ***dependent.*** Eligible children may be enrolled as ***dependents*** of one spouse, but not both.

TRANSFER OF COVERAGE

If a husband and wife are both ***employees*** and are covered as ***employees*** under this ***Plan*** and one of them terminates, the terminating spouse and any of the eligible, enrolled children will be permitted to immediately enroll under the remaining ***employee's*** coverage. Such new enrollment will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the ***employee*** or the ***dependent*** of the terminated ***employee.***

SPECIAL ENROLLMENT PERIOD: LOSS OF ELIGIBILITY FOR OTHER COVERAGE

An ***employee*** or ***dependent*** who did not enroll for coverage under this ***Plan*** because he was covered under other group coverage or had health coverage at the time he was initially eligible for coverage under this ***Plan***, may request a special enrollment period if he is no longer eligible for the other coverage. The ***employer*** may require proof of the Special Enrollment event noted below. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Legal separation or divorce;

2. A ***dependent*** child loses eligibility, for example, due to reaching the maximum age.

3. Death of spouse who had the coverage under the other plan;

4. Termination of other employment or reduction in number of hours of other employment;

5. Termination of the other coverage (including exhaustion of COBRA benefits);

6. Cessation of employer contributions toward the other coverage;

7. An individual in an HMO or other arrangement no longer resides, lives or works in the service area.

The end of any extended benefits period which has been provided due to any of the above will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage.)

The ***employee*** or ***dependent*** must request the special enrollment and enroll no later than thirty (30) days from the date of loss of other coverage.

The effective date of coverage as the result of a special enrollment shall be the first day of the first calendar month following the ***employer's*** receipt of the completed enrollment form.

SPECIAL ENROLLMENT PERIOD: DEPENDENT ACQUISITION

An ***employee*** who is not covered under the ***Plan***, but who acquires a new ***dependent*** may request a special enrollment period. The ***employer*** may require proof of the Special Enrollment event noted below. For the purposes of this provision, the acquisition of a new ***dependent*** includes:

1. Marriage;

2. Birth of a ***dependent*** child;

3. Adoption or placement for adoption of a ***dependent*** child.

The ***employee*** must request the special enrollment within thirty (30) days of the acquisition of the ***dependent.***

The effective date of coverage as the result of a special enrollment shall be:

1. In the case of marriage, the first day of the first calendar month following the ***employer's*** receipt of the completed enrollment form;

2. In the case of a ***dependent's*** birth, the date of such birth;

3. In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

SPECIAL ENROLLMENT PERIOD: MEDICAID AND CHIP ELIGIBILITY

An eligible ***employee,*** or an ***employee's*** eligible ***dependent,*** who is not enrolled under the ***Plan,*** shall be permitted to enroll for coverage hereunder if either of the following conditions are met:

1. Termination of Medicaid or CHIP Coverage: If the ***employee*** or ***dependent*** is covered under a state Medicaid plan under Title XIX of the Social Security Act, or under a state child health plan under Title XXI of the Social Security Act, and coverage of the ***employee*** or ***dependent*** under such other coverage is terminated as a result of loss of eligibility for such coverage.

2. Eligibility for Premium Assistance Under Medicaid or CHIP: If the ***employee*** or ***dependent*** becomes eligible for premium assistance, with respect to coverage under this ***Plan***, under a Medicaid plan or state child health plan.

The ***employee*** or ***dependent*** must submit a completed application for enrollment to the ***employer*** within sixty (60) days of either: (1) termination of coverage under such other coverage, or (2) the date the ***employee*** or ***dependent*** is determined to be eligible for premium assistance. Failure to submit the completed application for enrollment within the designated time shall result in the ***employee's*** or ***dependent's*** forfeiture of this enrollment right and shall be subject to enrolling upon the next open enrollment period sponsored by the ***employer***.

OPEN ENROLLMENT APPLIES TO MONTHLY MEASUREMENT PERIOD METHOD EMPLOYEES ONLY

Open enrollment is the period designated by the ***employer*** during which the ***employee*** may elect coverage for himself and any eligible ***dependents*** if he is not covered under the ***Plan*** and does not qualify for a Special Enrollment as described herein. Enrolled ***employees*** may add or drop coverage for enrolled ***dependents*** during this open enrollment period.

An open enrollment will be permitted once in each ***benefit year*** during a period selected by the ***employer***. Coverage changes shall be effective on the first day of the month following the open enrollment period, provided a properly completed application for enrollment is submitted to the ***employer*** during the designated open enrollment period and must be received by the ***employer*** by the last day of the open enrollment period.

ADMINISTRATIVE PERIOD APPLIES TO THE LOOK BACK MEASUREMENT PERIOD ONLY

The ***administrative period*** is the period designated by the ***employer*** during which the ***employee*** may elect coverage for himself and any eligible ***dependents.*** An ***administrative period*** will follow each ***measurement period. Ongoing employees*** may add or drop coverage for themselves or enrolled ***dependents,*** or may change benefit plan options for himself or any enrolled ***dependents*** during this ***administrative period***.

Coverage changes shall be effective on the first day of the following ***stability period***, provided a properly completed application for enrollment is submitted to the ***employer*** during the designated ***administrative period.***

LATE ENROLLMENT

With the exception of the provisions identified in *Special Enrollment* above, applications for ***employee*** or ***dependent*** coverage which are **not** filed with the ***employer*** within thirty (30) days of meeting the eligibility requirements of the ***Plan*** shall be subject to this late enrollment provision.

Late enrollment applicants shall be eligible to enroll for coverage during the ***Plan's*** annual open enrollment period. Coverage shall become effective the first of the month following the open enrollment period provided a properly completed application for enrollment has been received by the ***employer***. This late enrollment provision shall not apply to an ***alternate recipient.***

WAIVER OF COVERAGE

Employees who elect not to enroll themselves and/or their ***dependents*** must complete a waiver of coverage form. The waiver of coverage must be submitted to the ***employer*** within thirty (30) days of the date coverage would otherwise be effective under this ***Plan.*** If waiver of coverage is due to the existence of other group health coverage upon meeting the ***Plan's*** eligibility requirements, it is the ***employee's*** responsibility to notify the ***employer*** in writing of the existence of the other coverage and this is the reason for waiving coverage upon meeting the eligibility requirements.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE(S) EFFECTIVE DATE

If the ***employee*** does not enroll for coverage within thirty (30) days of meeting the ***Plan's*** eligibility requirements, the ***effective date*** of coverage will be delayed. Refer to the section entitled, *Enrollment.*

NEW HIRES

Full-time, Regular Employees on the Monthly Measurement or Look Back Measurement Period Method

Eligible ***full-time, regular employees,*** as described in, *Eligibility,* are covered under the ***Plan*** on the first of the month following a sixty (60) day waiting period, provided a properly completed enrollment form was submitted to the ***employer.***

If the ***employee*** does not enroll for coverage within thirty (30) days of meeting the ***Plan's*** eligibility requirements, the ***effective date*** of coverage will be delayed. Refer to *Enrollment*.

Part-time Employees on the Monthly Measurement Period Method

In the event a ***part-time employee*** changes employment status to ***full-time, regular employee,*** coverage will be effective on the first day of the month following the date the ***employee*** meets the ***Plan's*** eligibility requirements, provided the ***employee*** worked in a ***part-time*** capacity for the ***employer*** for at least the period of time equal to the ***Plan's*** waiting period, and provided a properly completed application or enrollment to the ***employer.***

Qualifying Part-time Employees on the Look Back Measurement Period

Eligible ***qualifying part-time employees*** will be effective on the first day of the ***qualifying part-time employee's new employee stability period*** provided a properly completed application for enrollment was submitted to the ***employer*** by the end of the ***administrative period.*** A ***qualifying part-time employee*** will remain eligible throughout the ***new employee stability period*** and therefore, covered under the ***Plan,*** to the extent that the ***employee*** remains employed, subject to the ***Plan's break in service*** rules, and *Termination of Coverage* provisions of the ***Plan.***

ONGOING EMPLOYEES ON THE LOOK BACK MEASUREMENT PERIOD METHOD

Eligible ***ongoing employees*** will be effective on the first day of the ***Plan's ongoing employee stability period,*** provided a properly completed application for enrollment was submitted to the ***employer*** by the end of the ***administrative period.***

DEPENDENT(S) EFFECTIVE DATE

Eligible ***dependent(s),*** as described in *Eligibility,* will become covered under the ***Plan*** on the later of the dates listed below, provided the ***employee*** has enrolled them in the ***Plan*** within thirty (30) days of meeting the ***Plan's*** eligibility requirements. If the ***employee*** does not enroll eligible ***dependents*** within thirty (30) days of meeting the ***Plan's*** eligibility requirements, the ***dependents' effective date*** of coverage will be delayed. Refer to *Enrollment*.

1. The date the ***employee's*** coverage becomes effective.

2. The date the ***dependent*** is acquired, provided any required contributions are made and the ***employee*** has applied for ***dependent*** coverage within thirty (30) days of the date acquired.

3. Newborn children shall be covered from birth, regardless of ***confinement,*** provided the ***employee*** has applied for ***dependent*** coverage within thirty (30) days of birth. However, if the ***employee*** already has other ***dependents*** covered under this ***Plan*** when a child is born, additional enrollment for that child will be required.

4. Coverage for a newly adopted child shall be effective on the date the child is ***placed for adoption.***

TERMINATION OF COVERAGE

Except as provided in the ***Plan's*** *Continuation of Coverage* (COBRA) provision, coverage will terminate on the earliest of the following dates:

EMPLOYEE(S) TERMINATION DATE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.

2. The last day of the month in which the ***employee*** ceases to meet the eligibility requirements of the ***Plan.***

3. The last day of the month in which employment terminates.

4. The date the ***employee*** becomes a ***full-time,*** active member of the armed forces of any country.

5. The date the ***employee*** ceases to make any required contributions.

DEPENDENT(S) TERMINATION DATE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.

2. The date the ***employee's*** coverage terminates. However, if the ***employee*** remains eligible for the ***Plan,*** but elects to discontinue coverage, coverage may be extended for ***alternate recipients.***

3. The date such person ceases to meet the eligibility requirements of the ***Plan.***

4. The date the ***employee*** ceases to make any required contributions on the ***dependent's*** behalf.

5. The date the ***dependent*** becomes a ***full-time,*** active member of the armed forces of any country.

6. The date the ***Plan*** discontinues ***dependent*** coverage for any and all ***dependents.***

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents,*** when the ***employee*** is on an authorized ***leave of absence*** from the ***employer.*** In no event will coverage continue beyond the end of the twelve (12) calendar week period that next follows the month in which the person last worked as an active ***employee***.

LAYOFF

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents,*** when the ***employee*** is subject to an ***employer layoff.*** In no event will coverage continue beyond the end of the twelve (12) calendar week period that next follows the month in which the person last worked as an active ***employee***.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An ***employee*** who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this ***Plan*** while on an approved leave. The duration of leave is contingent upon the reason for the leave as follows:

1. Up to twelve (12) workweeks during a twelve (12) month period:
   - A. for the birth and care of the newborn child of the ***employee***;
   - B. for placement with the ***employee*** of a son or daughter for adoption or foster care;
   - C. to care for an immediate family member (spouse, child, or parent) with a serious health condition; or
   - D. to take medical leave when the ***employee*** is unable to work because of a serious health condition.

For the purposes of this provision, the above shall be referred to as: Other FMLA Qualifying Reasons.

2. Up to twenty-six (26) workweeks during a twelve (12) month period to care for a service member who is undergoing medical treatment, recuperation, or therapy, is otherwise in an outpatient status or is otherwise on temporary disability retired list for a serious ***injury*** or ***illness*** incurred in the line of duty on active duty. For the purpose of the provision, “service member” is defined as a current member of the Armed Forces, including a member of the National Guard or Reserves. This shall be referred to as: Military Caregiver Leave.
3. Up to twelve (12) workweeks during a twelve (12) month period due to a spouse, son, daughter, or parent who is a member of one of the U.S. Armed Force’s Reserve components or National Guard on active duty or is a reservist or member of the National Guard who faces recall to active, federal service by the President if a qualifying exigency exists. This shall be referred to as: Qualifying Exigency Leave.

An ***employee*** who is eligible for FMLA leave is entitled to a combined total of twenty-six (26) workweeks of leave for Military Caregiver Leave and leave for any Other FMLA Qualifying Reason during the same single 12-month period provided that the ***employee*** takes no more than twelve (12) workweeks of leave because of a Qualifying Exigency Leave or for any Other FMLA Qualifying Reason.

Contributions

During this leave, the ***employer*** will continue to pay the same portion of the ***employee's*** contribution for the ***Plan.*** The ***employee*** shall be responsible to continue payment for eligible ***dependent's*** coverage and any remaining ***employee*** contributions. If the covered ***employee*** fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement

If coverage under the ***Plan*** was terminated during an approved FMLA leave, and the ***employee*** returns to active work immediately upon completion of that leave, ***Plan*** coverage will be reinstated on the date the ***employee*** returns to active work as if coverage had not terminated, provided the ***employee*** makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to active work.

Repayment Requirement

The ***employer*** may require ***employees*** who fail to return from a leave under FMLA to repay any contributions paid by the ***employer*** on the ***employee's*** behalf during an unpaid leave. This repayment will be required only if the ***employee's*** failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the ***employee's*** control.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this ***Plan*** includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Public Health Services Act. This continuation of coverage may be commonly referred to as "COBRA coverage."

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical, prescription drug, dental and vision benefits as provided under the ***Plan.***

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a ***covered person*** to lose coverage under this ***Plan,*** even if such coverage is not lost immediately, and allow such person to continue coverage beyond the date described in *Termination of Coverage:*

1. Death of the ***employee.***

2. The ***employee's*** termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the ***Plan.***

3. Divorce or legal separation from the ***employee.***

4. The ***employee's*** entitlement to ***Medicare*** benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this ***Plan.***

5. A ***dependent*** child no longer meets the eligibility requirements of the ***Plan.***

6. The last day of leave under the Family Medical Leave Act of 1993.

7. The call-up of an ***employee*** reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered ***employee,*** or a child's loss of ***dependent*** status, the ***employee*** or ***dependent*** must notify the ***employer*** of that event within sixty (60) days of the event**. Failure to provide such notice to the *employer* will result in the person forfeiting their rights to continuation of coverage under this provision.**

2. The ***employer*** has thirty (30) days to notify the ***claims administrator*** of the qualifying event. Within fourteen (14) days of receiving notice of a qualifying event, the ***claims administrator*** will notify the ***employee*** or ***dependent*** of his rights to continuation of coverage, and what process is required to elect continuation of coverage.

3. After receiving notice, the ***employee*** or ***dependent*** has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the ***Plan*** prior to the qualifying event, has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the ***employee*** or ***dependent*** chooses to have continued coverage, he must advise the ***employer*** in writing of this choice. The ***employer*** must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the latter of the following:

   A. The date coverage under the ***Plan*** would otherwise end; or

B. The date the person receives the notice from the ***employer*** of his or her rights to continuation of coverage.

4. Within forty-five (45) days after the date the person notifies the ***employer*** that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day each month.

5. The ***employee*** or ***dependent*** must make payments for the continued coverage.

COST OF COVERAGE

1. The ***employer*** requires that ***covered persons*** pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. This must be remitted to the ***employer*** or the ***employer's*** designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

2. For purposes of determining monthly costs for continued coverage, a person originally covered as an ***employee*** or as a spouse will pay the rate applicable to an ***employee*** if coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to an ***employee.***

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for ***dependents*** acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the ***Plan.***

Since a reduction in employment hours is a qualifying event under this provision, any continuation of coverage granted by the ***employer*** (***leave of absence, layoff,*** shall run simultaneously with the continuation of coverage provided under this provision (COBRA).

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent.*** The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

SUBSEQUENT QUALIFYING EVENTS

Once covered under continuation coverage, it is possible for a second qualifying event to occur, including:

1. Death of an ***employee.***

2. Divorce or legal separation from an ***employee.***

3. ***Employee's*** entitlement to ***Medicare.***

4. The child's loss of ***dependent*** status.

If one of these subsequent qualifying events occurs, a ***dependent*** may be entitled to a second continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first qualifying event.

Only a person covered prior to the original qualifying event or a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other ***dependent*** acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months from the date continuation began because of a reduction of hours or termination of employment of the ***employee.***

2. Thirty-six (36) months from the date continuation began for ***dependents*** whose coverage ended because of the death of the ***employee,*** divorce or legal separation from the ***employee,*** or the child's loss of ***dependent*** status.

3. The end of the period for which contributions are paid if the ***covered person*** fails to make a payment on the date specified by the ***employer.***

4. The date coverage under this ***Plan*** ends and the ***employer*** offers no other group health benefit plan.

5. The date the ***covered person*** first becomes entitled to ***Medicare*** after the original date of the ***covered person's*** election of continuation coverage.

6. The date the ***covered person*** first becomes covered under any other group health plan after the original date of the ***covered person's*** election of continuation coverage.

EXTENSION FOR DISABLED INDIVIDUALS

A person who is ***totally disabled*** may extend continuation coverage from eighteen (18) months to twenty-nine (29) months. The person must be disabled for Social Security purposes at the time of the qualifying event or within sixty (60) days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the ***employer*** within the initial eighteen (18) month continuation coverage period and no later than sixty (60) days after the Social Security Administration's determination. The disabled person and the family members who were covered prior to the qualifying event are eligible for up to twenty-nine (29) months of continuation of coverage. The ***employer*** may charge 150% of the contribution during the additional eleven (11) months of continuation of coverage. Extended coverage will end the month that begins thirty (30) days after the person is no longer considered disabled.

MILITARY MOBILIZATION

If an ***employee*** is called for active duty by the United States Armed Services (including the Coast Guard), the National Guard or the Public Health Service, the ***employee*** may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the ***employee*** may not be required to pay more than the ***employee's*** share, if any, applicable to that coverage. If the leave is more than thirty-one (31) days, then the ***employer*** may require the ***employee*** to pay no more than 102% of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or

2. A period beginning on the day that the leave began and ending on the day after the ***employee*** fails to return to employment within the time allowed.

Whether or not the individual elects continuation of coverage under USERRA, upon return from uniformed service, the ***employee's*** coverage will be reinstated the date of return to work, provided the uniformed service member was released under honorable conditions, and returns to work within the following timelines:

1. Following completion of the military service for a leave of less than thirty-one (31) days, upon the first full regularly scheduled work period after the expiration of eight (8) hours after a period allowing for the safe transportation of the person from the place of service to the person's residence.

2. Within fourteen (14) days of completing military service for a leave of thirty-one (31) days to one hundred eighty (180) days;

3. Within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days.

The ***Plan*** shall be reinstated without exclusions other than for a period or exclusions that would have applied even if there had been no absence for uniformed service.

CLAIM FILING PROCEDURE

FILING A CLAIM

1. A claim form is to be completed on each covered family member at the beginning of the ***benefit year*** and for each claim involving an ***injury***. Appropriate claim forms are available from the Human Resources Department.

2. All bills submitted for benefits must contain the following:

   A. Name of patient.
   B. Patient's date of birth.
   C. Name of ***employee.***
   D. Address of ***employee.***
   E. Name of ***employer.***
   F. Name, address and tax identification number of provider.
   G. ***Employee*** Social Security number.
   H. Date of service.
   I. Diagnosis.
   J. Description of service and procedure number.
   K. Charge for service.
   L. The nature of the accident, Injury or Illness being treated.

3. Properly completed claims not submitted within one (1) year of the date of incurred liability will be denied.

The ***covered person*** may ask the provider to submit the bill directly to the ***claims processor,*** or the ***covered person*** may file the bill with a claim form. However, it is ultimately the ***covered person's*** responsibility to make sure the claim has been filed for benefits.

Proof of Payment of Deductible

To obtain benefits under this ***Plan,*** the ***covered person*** must submit proof to the ***claims processor*** that the deductible for the ***benefit year*** has been incurred. Proof will include an itemized bill on the provider's letterhead or statement and the diagnosis.

FOREIGN CLAIMS

In the event a ***covered person*** incurs a ***covered expense*** in a foreign country, the ***covered person*** shall be responsible for providing the following to the ***claims processor*** before payment of any benefits due are payable:

1. The claim form, provider invoice and any other documentation required to process the claim must be submitted in the English language.

2. The charges for services must be converted into dollars.

3. A current conversion chart validating the conversion from the foreign country's currency into dollars.

NOTICE OF CLAIM

A claim for benefits should be submitted to the ***claims processor*** within ninety (90) days after the occurrence or commencement of any services covered by the ***Plan,*** or as soon thereafter as reasonably possible. Benefits are based on the ***Plan's*** provisions at the time the expenses were incurred.

Failure to file a claim within the time provided shall not invalidate or reduce any claim if it shall be shown that: (1) it was not reasonably possible to file a claim within that time; (2) and that such claim was furnished as soon as possible, but no later than one (1) year after the loss occurs or commences, unless the claimant is legally incapacitated.

Notice given by or on behalf of a ***covered person*** or his beneficiary, if any, to the ***Plan administrator*** or to any authorized agent of the ***Plan*** with information sufficient to identify the ***covered person,*** shall be deemed notice of claim.

PAYMENT OF BENEFITS

After a claim has been submitted to the ***claims processor,*** if additional information is needed for payment of the claim, the ***claims processor*** will request the same. The ***claims processor*** will approve, partially approve, or deny the claim within thirty (30) days after all necessary information is received by the ***claims processor*** to determine the validity of the claim. This time period may be extended for fifteen (15) days if it is necessary because of matters beyond the ***Plan's*** control, and if the ***Plan*** notifies the ***covered person*** of those circumstances and the expected date of decision before the end of the thirty (30) day period. This Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. The ***employee*** will be allowed up to forty-five (45) calendar days from receipt of the Notice of Extension to provide the additional information. The ***Plan*** will then make a claim determination within a reasonable period but not later than fifteen (15) calendar days from the date the ***Plan*** receives the additional information.

If the services of a ***preferred provider*** are used, ***Plan*** benefits are payable directly to the provider of service. If the services of a ***nonpreferred provider*** are used, benefits are payable to the ***covered person*** whose ***illness*** or ***injury,*** or whose ***dependent's illness*** or ***injury,*** is the basis of claim under this ***Plan,*** unless the ***covered person*** has made an assignment of benefits to the provider of service.

In the event a claim for benefits under the ***Plan*** is denied in whole or in part, the ***covered person*** will receive written notification stating the required information including the review procedure, in the same fashion as reimbursement for a claim, in a manner calculated to be understood by the ***covered person.*** A claim worksheet will be provided by the ***claims processor*** showing the calculation of the total amount payable, charges not payable, and the reason.

APPEALING A CLAIM

Review Procedures

A ***covered person,*** or the ***covered person's*** representative may request a review of the claim denial by making written request to the ***claims processor*** within one-hundred-eighty (180) days of receipt of the notice of denial. Written notice for review should:

1. State the reasons the ***covered person*** feels the claim should not have been denied; and

2. Include any additional documentation which the ***covered person*** believes supports the claim.

On receipt of written request for review of a claim, the ***claims processor*** will review the claim and furnish copies to the ***employer*** of all documents and all reasons and facts relative to the decision. An ***employee,*** or his authorized representative, may examine all pertinent documents which the ***claims processor*** may have, excluding any medical records of a confidential nature, and submit an opinion in writing of the issues and his comments to the ***employer.***

Decision on Review

Decision by the ***employer*** will be made within sixty (60) days of receipt of the written opinion unless special circumstances require more time, then the decision shall be rendered as soon as possible, but no later than one-hundred-twenty (120) days after receipt of the ***covered person's*** request for review. This decision will also be delivered to the ***covered person*** in writing, setting forth specific reasons for the decision and specific references to the pertinent ***Plan*** provisions upon which the decision is based. The decision is final.

INTERNAL AND EXTERNAL APPEAL PROCESS

The ***Plan*** shall maintain an Internal Appeals and an External Appeals Process in accordance with the following:

Internal Appeals Process

1. Clarification of "Adverse Benefit Determination": The scope of an "adverse benefit determination" eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).

2. Full and Fair Review: The ***Plan*** shall provide a ***covered person*** (free of charge) any new or additional evidence considered, relied upon or generated by the ***Plan*** in connection with a claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the ***covered person*** to respond to such new evidence or rationale before a final adverse benefit determination is made.

3. Avoidance of Any Conflict of Interest: The ***Plan*** must ensure any decisions related to hiring, compensation, termination, promotion or other similar matters with respect to any individual in the claims decision process, such as a ***claims processor*** or medical expert, may not be based on the likelihood that the individual will support the denial of benefits.

4. Notices - Content Requirements: Any notice of an adverse benefit determination or final internal adverse benefit determination must include the following:

   A. Claim Identification. Information sufficient to identify the claim involved, including the date of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

   B. Rationale for Denial. The reason or reasons for an adverse benefit determination including the denial code and its corresponding meaning and a description of the standard(s) applied in denying the claim. A notice of a final internal adverse benefit determination must also include a discussion of the decision.

   C. Claims and Appeal Procedures. The ***Plan*** must provide a description of the available internal and external review processes (including information on how to initiate an appeal).

   D. Consumer Assistance. The ***Plan*** must disclose the availability of and contact information for any outside applicable office to assist ***covered persons*** with the claims, appeals, and external review processes.

5. Deemed Exhaustion of Internal Claims and Appeals Processes: If the ***Plan*** fails to strictly adhere to all requirements of the Internal Claims and Appeals, a ***covered person*** will be deemed to have exhausted the internal claims and appeals process, regardless of whether the ***Plan*** asserts that it has substantially complied, and the ***covered person*** may initiate any available external review process or remedies available at law.

Standard External Appeals Process

1. Request for External Review: The ***Plan*** will allow a ***covered person*** to file a request for an external review if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth (5th) month following the receipt of the notice. (For example, if the date of receipt of the notice is October 30th, because there is no February 30th, the request must be filed by March 1st). If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary Review: Within five (5) business days following the date of receipt of the external review request, the ***Plan*** will complete a preliminary review of the request to determine whether:

A. The ***covered person*** is or was covered under the ***Plan*** at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the ***Plan*** at the time the health care item or service was provided;

B. The adverse benefit determination or the final adverse benefit determination does not relate to the ***covered person's*** failure to meet the requirements for eligibility under the terms of the ***Plan***.

C. The ***covered person*** has exhausted the ***Plan's*** internal appeal process.

D. The ***covered person*** has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the ***Plan*** will issue a notification in writing to the ***covered person*** or the ***covered person's*** authorized representative. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272). If the request is not complete, such notification will include the information or materials needed to make the request complete and the ***Plan*** will allow a ***covered person*** to perfect the request for external review within the four (4) month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization (IRO): The ***Plan*** will assign an independent review organization (IRO) that is accredited by URAC or by similar nationally recognized accrediting organization to conduct the external review. The ***Plan*** will also take action to ensure against bias and to ensure independence. To do this, the ***Plan*** will contract with at least three (3) IROs for assignments under the ***Plan*** and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). An IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Minimum Standards for IRO Contract: A contract between the ***Plan*** and an IRO must provide the following:

A. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the ***Plan.***

B. The assigned IRO will timely notify the ***covered person*** in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the ***covered person*** may submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.

C. Within five (5) business days after the date of assignment of the IRO, the ***Plan*** must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the ***Plan*** to timely provide the documents and information must not delay the conduct of the external review. If the ***Plan*** fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one (1) business day after making the decision, the IRO must notify the ***covered person*** and the ***Plan***.

D. Upon receipt of any information submitted by the ***covered person***, the assigned IRO must within one (1) business day forward the information to the ***Plan***. Upon receipt of any such information, the ***Plan*** may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the ***Plan*** must not delay the external review. The external review may be terminated as a result of the reconsideration only if the ***Plan*** decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one (1) business day after making such a decision, the ***Plan*** must provide written notice of its decision to the ***covered person*** and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the ***Plan***.

E. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the ***Plan's*** internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the PHS Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

i. The ***covered person***'s medical records;
ii. The attending health care professional's recommendation;
iii. Reports from appropriate health care professionals and other documents submitted by the plan or issuer, ***covered person***, or ***covered person***'s treating provider;
iv. The terms of the ***covered person***'s ***Plan*** to ensure that the IRO's decision is not contrary to the terms of the ***Plan***, unless the terms are inconsistent with applicable law;
v. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
vi. Any applicable clinical review criteria developed and used by the ***Plan***, unless the criteria are inconsistent with the terms of the ***Plan*** or with applicable law; and
vii. The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

F. The assigned IRO must provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the ***covered person*** and the ***Plan***.

G. The assigned IRO's decision notice will contain:

i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
iii. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
iv. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the ***covered person***;
v. A statement that judicial review may be available to the ***covered person***; and
vi. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHA Act section 2793.

H. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the ***covered person***, ***Plan***, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

5. Reversal of ***Plan's*** Decision: Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the ***Plan*** immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Reviews

1. Request for Expedited External Review: The ***Plan*** must allow a ***covered person*** to make a request for an expedited external review with the ***Plan*** at the time the ***covered person*** receives:

A. An adverse benefit determination if the adverse benefit determination involves a medical condition of the ***covered person*** for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the ***covered person*** or would jeopardize the ***covered person***'s ability to regain maximum function and the ***covered person*** has filed a request for an expedited internal appeal; or

B. A final internal adverse benefit determination, if the ***covered person*** has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the ***covered person*** or would jeopardize the ***covered person***'s ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the ***covered person*** received ***emergency*** services, but has not been discharged from a ***facility***.

2. Preliminary Review: Immediately upon receipt of the request for expedited external review, the ***Plan*** must determine whether the request meets the reviewability requirements set forth in paragraph 2 above for standard external review. The ***Plan*** must immediately send a notice that meets the requirements set forth in paragraph 2 above for standard external review to the ***covered person*** of its eligibility determination.

3. Referral to Independent Review Organization: Upon a determination that a request is eligible for external review following the preliminary review, the ***Plan*** will assign an IRO pursuant to the above requirements for standard review. The ***Plan*** must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the ***Plan's*** internal claims and appeals process.

4. Notice of Final External Review Decision: The ***Plan's*** contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the ***covered person***'s medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the ***covered person*** and the ***Plan***.

COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the ***covered person*** is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed 100% of "allowable expenses." Only the amount paid by this ***Plan*** will be charged against the ***maximum benefit.***

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses incurred while covered under this ***Plan,*** part or all of which would be covered under this ***Plan***. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this ***Plan.***

When this ***Plan*** is secondary, "Allowable Expense" will include any deductible or ***coinsurance*** amounts not paid by the Other Plan(s).

When this ***Plan*** is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the ***covered person*** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for ***covered persons*** in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;

2. Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

5. Any coverage under a government program and any coverage required or provided by any statute;

6. Group automobile insurance;

7. Individual automobile insurance coverage;

8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

9. Any plan or policies funded in whole or in part by an ***employer,*** or deductions made by an ***employer*** from a person's compensation or retirement benefits;

10. Labor/management trustee, union welfare, employer organization, or employee benefit organization plans.

"This ***Plan"*** shall mean that portion of the ***employer's Plan*** which provides benefits that are subject to this provision.

"Claim Determination Period" means a ***benefit year*** or that portion of a ***benefit year*** during which the ***covered person*** for whom a claim is made has been covered under this ***Plan.***

AUTOMOBILE LIMITATIONS

When medical payments are available under vehicle insurance, the ***Plan*** shall pay excess benefits only, without reimbursement for vehicle plan deductibles. The ***Plan*** shall always be considered the secondary carrier regardless of the individual's election under personal injury protection with the auto insurance carrier.

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a ***covered person*** for each claim determination period for the Allowable Expenses. If this ***Plan*** is secondary, the benefits that would be payable under this ***Plan*** for each claim in the absence of this provision shall be calculated and reduced by the benefits payable under all other plans for the expenses covered in whole or in part by this ***Plan***.

If the rules set forth below would require this ***Plan*** to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this ***Plan***.

ORDER OF BENEFIT DETERMINATION

Each plan will make its claim payment according to the following order of benefit determination:

1. No Coordination of Benefits Provision
   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. Member/Dependent
   The plan which covers the claimant as a member (or named insured) pays as though no Other Plan existed. Remaining ***covered expenses*** are paid under a plan which covers the claimant as a ***dependent.***

3. Dependent Children of Parents not Separated or Divorced
   The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. Dependent Children of Separated or Divorced Parents
   When parents are separated or divorced, the birthday rule does not apply, instead:

   A. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent pays fourth.
   B. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody pays fourth.

5. Active/Inactive
   The plan covering a person as an active (not laid off or retired) ***employee,*** or as that person's ***dependent*** pays first. The plan covering that person as a laid off or retired ***employee,*** or as that person's ***dependent*** pays second.

6. Limited Continuation of Coverage

If a person is covered under another group health plan, but is also covered under this ***Plan*** for continuation of coverage due to the Other Plan's exclusions, the Other Plan shall be primary for all ***covered expenses*** which are not related to the exclusions.

7. Longer/Shorter Length of Coverage
If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

COORDINATION WITH MEDICARE

Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for ***Medicare*** Part A at no cost. Participation in ***Medicare*** Part B is available to all individuals who make application and pay the full cost of the coverage.

1. When an ***employee*** becomes entitled to ***Medicare*** coverage and is still ***actively at work,*** the ***employee*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

2. When a ***dependent*** becomes entitled to ***Medicare*** coverage and the ***employee*** is still ***actively at work,*** the ***dependent*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

3. If the ***employee*** and/or ***dependent*** is also enrolled in ***Medicare,*** this ***Plan*** shall pay as the primary plan. ***Medicare*** will pay as secondary plan.

4. If the ***employee*** and/or ***dependent*** elect to discontinue health coverage under this ***Plan*** and enroll under the ***Medicare*** program, no benefits will be paid under this ***Plan.*** ***Medicare*** will be the only payor.

This section is subject to the standard terms of the ***Medicare*** Secondary Payor laws and regulations, including but not limited to, determination of first and second payor for a person with End Stage Renal Disease, or a person eligible for Medicare due to disability. Any changes in these related laws and regulations will apply to the provisions of this section.

LIMITATIONS ON PAYMENTS

In no event shall the ***covered person*** recover under this ***Plan*** and all Other Plan(s) combined more than the total Allowable Expenses offered by this ***Plan*** and the Other Plan(s). Nothing contained in this section shall entitle the ***covered person*** to benefits in excess of the total ***maximum benefits*** of this ***Plan*** during the claim determination period. The ***covered person*** shall refund to the ***employer*** any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the ***Plan*** may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information with respect to any ***covered person.*** Any person claiming benefits under this ***Plan*** shall furnish to the ***employer*** such information as may be necessary to implement the *Coordination of Benefits* provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this ***Plan*** in accordance with this provision have been made under any Other Plan, the ***employer*** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this ***Plan*** and, to the extent of such payments, the ***employer*** shall be fully discharged from liability.

SUBROGATION/REIMBURSEMENT

The ***Plan*** maintains the right to seek reimbursement on its own behalf: the right of subrogation. The ***Plan*** also reserves the right to reimbursement upon a ***covered person's*** (a covered ***employee*** or a covered dependent) receipt of settlement, judgment, or award: the right of reimbursement. The ***Plan*** reserves the right of recovery, either by subrogation or reimbursement, for ***covered expenses*** payable by the ***Plan*** which are a result of ***illness*** or ***injury***. The ***Plan*** shall be reimbursed from the first monies recovered as the result of judgment, settlement or otherwise. (This is known as "Pro tanto" subrogation.) This right includes the ***Plan's*** right to receive reimbursement from uninsured or underinsured motorist coverage and no-fault coverage.

Accepting benefits from this ***Plan*** automatically assigns to it any rights the ***covered person*** may have to recover benefits from any party, including an insurer or another group health program. This right of recovery allows the ***Plan*** to pursue any claim which the ***covered person*** may have against any party, group health program or insurer, whether or not the ***covered person*** chooses to pursue that claim. This includes a right to recover from no-fault auto insurance carriers in a situation where no third party may be liable, or from any uninsured or underinsured motorist coverage where the recovery was triggered by the actions of a party which caused or contributed to the payment of benefits under this ***Plan.*** This also includes a right to recover from amounts the ***covered person*** received from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid benefits prior to a determination that the medical expenses arose out of and in the course of employment. Payment by workers' compensation will be presumed to mean that such a determination has been made.

If a ***covered person*** is involved in an automobile accident, or suffers an ***illness*** or ***injury*** that was due to the action or inaction of any party, the ***Plan*** may advance payment in order to prevent any financial hardship to the ***covered person.*** Acceptance of ***Plan*** benefits acknowledges (1) the obligation of the ***covered person*** to help the ***Plan*** to recover benefits it has paid out on behalf of the ***covered person,*** and (2) to provide the ***Plan*** with information concerning: any automobile insurance, any other group health program which may be obligated to pay benefits on behalf of the ***covered person,*** and the insurance of any other party involved. The ***covered person*** is required to cooperate fully in the ***Plan's*** exercise of its right to recovery and the ***covered person*** cannot do anything to prejudice those rights. Such cooperation is required as a condition of receiving benefits under the ***Plan.*** The ***Plan administrator*** may refuse to pay benefits, or cease to pay benefits, on behalf of a ***covered person*** who fails to sign any document deemed by the ***Plan administrator*** to be relevant to protecting its subrogation rights or fails to provide relevant information when requested. The term information includes any documents, insurance policies, police reports, or any reasonable request by the ***claims processor*** or ***Plan administrator*** to enforce the ***Plan's*** rights.

Whether the ***covered person*** or the ***Plan*** makes a claim directly against any party, group health program or insurance company for the benefit payments made on behalf of a ***covered person*** by the ***Plan,*** the ***Plan*** has a lien on any amount the ***covered person*** recovers or could recover from any party, insurance company, or group health program whether by judgment, settlement, or otherwise, and whether or not designated as payment for medical expenses. This lien shall remain in effect until the ***Plan*** acknowledges and agrees upon payment to the ***Plan*** and releases its lien. The lien may not be for an amount greater than the amount of benefits paid under the ***Plan.***

Failure to reimburse the ***Plan*** for ***covered expenses*** paid by the ***Plan*** that were also paid by a third party otherwise responsible shall result in a reduction of future claim benefits of a ***covered person*** up to the aggregate amount the ***Plan*** has paid.

The ***Plan administrator*** has delegated to the ***claims processor*** the right to perform ministerial functions required to assert the ***Plan's*** rights; however, the ***Plan administrator*** shall retain discretionary authority with regard to asserting the ***Plan's*** recovery rights.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The ***Plan*** is administered through the Human Resources Department of the ***employer.*** The ***employer*** is the ***Plan administrator.*** The ***Plan administrator*** shall have full charge of the operation and management of the ***Plan.*** The ***employer*** has retained the services of an independent ***claims processor*** experienced in claims review.

The ***employer*** is the named fiduciary of the ***Plan.*** As fiduciary, the ***employer*** maintains discretionary authority to review all denied claims for benefits under the ***Plan*** with respect to which it has been designated named fiduciary, including, but not limited to, the denial of certification of the ***medical necessity*** of ***hospital*** or medical services, supplies and treatment, to interpret the terms of the ***Plan,*** and to determine eligibility for and entitlement to ***Plan*** benefits in accordance with the terms of the ***Plan.***

ASSIGNMENT

The ***Plan*** will pay benefits under this ***Plan*** to the ***employee*** unless payment has been assigned to a ***hospital, physician,*** or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the ***Plan*** unless the ***claims processor*** is notified in writing of such assignment prior to payment hereunder. This ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a qualified medical child support order.

Preferred providers normally bill the ***Plan*** directly. If services, supplies or treatment has been received from such a provider, benefits are automatically paid to that provider. The ***covered person's*** portion of the ***negotiated rate,*** after the ***Plan's*** payment, will then be billed to the ***covered person*** by the ***preferred provider.***

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible ***covered person*** is entitled to receive benefits under this ***Plan.*** Such right to benefits is not transferable.

CLERICAL ERROR

For termination of coverage for an ***employee's*** coverage or ***dependent*** coverage, the ***employer*** may make an adjustment of contributions on the next monthly billing of up to ninety (90) days retroactively after the error or delay is discovered and submitted to the ***claims processor.*** No adjustments will be made in coverage or contributions for more than ninety (90) days retroactively.

For implementation of coverage for an ***employee*** whose application for enrollment was not submitted to the ***claims processor*** by the ***employer*** within thirty (30) days of the eligibility date, the ***employee*** will be effective coincident with or on the first of the month following receipt by the ***claims processor*** of a properly completed application for enrollment.

For implementation of coverage for ***dependent*** coverage: In the event that ***employer*** payroll deductions for family coverage occurred and the application for enrollment of ***dependent*** coverage was not submitted to the ***claims processor,*** the ***employee*** and ***dependents*** shall be enrolled for coverage retroactively to the applicable date of coverage, provided proof of payroll deductions are submitted to the ***claims processor*** with the application for enrollment. ***Employees*** and ***dependents*** will be added retroactive to the original effective date following the completion of any waiting period. In the event that payroll records are not provided, ***dependents*** may be added at the next open enrollment period, and the ***employee's*** coverage will be effective first of the month following receipt of the completed application for enrollment by the ***claims processor.***

CONFORMITY WITH STATUTE(S)

Any provision of the ***Plan*** which is in conflict with statutes which are applicable to this ***Plan*** is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The original ***effective date*** of this ***Plan*** is October 1, 2015.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this ***Plan*** shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a ***hospital*** or to make a free choice of the attending ***physician*** or ***professional provider.*** However, benefits will be paid in accordance with the provisions of this ***Plan,*** and the ***covered person*** will have higher out-of-pocket expenses if the ***covered person*** uses the services of a ***nonpreferred provider.***

INCAPACITY

If, in the opinion of the ***employer,*** a ***covered person*** for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the ***Plan*** of the qualification of a guardian or personal representative for his estate, the ***employer*** may on behalf of the ***Plan,*** at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the ***Plan's*** obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the ***employer*** or by the ***employee*** covered under this ***Plan*** shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this ***Plan*** or be used in defense to a claim unless they are contained in writing and signed by the ***employer*** or by the ***covered person,*** as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the ***Plan*** prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the ***Plan.*** No such action shall be brought after the expiration of two (2) years from the date the expense was ***incurred,*** or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the ***employer*** shall not be liable for any obligation of the ***covered person incurred*** in excess thereof. The ***employer*** shall not be liable for the negligence, wrongful act, or omission of any ***physician, professional provider, hospital,*** or other institution, or their employees, or any other person. The liability of the ***Plan*** shall be limited to the reasonable cost of ***covered expenses*** and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the ***Plan administrator*** is unable to locate the ***covered person*** to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the ***covered person*** for the forfeited benefits within the time prescribed in *Claim Filing Procedure.*

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The ***Plan*** will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a ***covered person*** or in determining or making any payment of benefits to that individual. The ***Plan*** will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this ***Plan*** has a legal liability to make payments for the same services, supplies or treatment, payment under the ***Plan*** will be made in accordance with any State law which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the ***Plan.***

MISREPRESENTATION

If the ***covered person*** or anyone acting on behalf of a ***covered person*** makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the ***Plan,*** or otherwise misleads the ***Plan,*** the ***Plan*** shall be entitled to recover its damages, including legal fees, from the ***covered person,*** or from any other person responsible for misleading the ***Plan,*** and from the person for whom the benefits were provided. Any material misrepresentation on the part of the ***covered person*** in making application for coverage, or any application for reclassification thereof, or for service there under shall render the coverage under this ***Plan*** null and void.

In the event an ***employee*** enrolled in the ***Plan*** fraudulently or with intentional misrepresentation of a material fact, the coverage under this ***Plan*** shall be terminated upon a thirty (30) day advance, written notice to the ***employee.***

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The ***Plan,*** at its own expense, shall have the right to require an examination of a person covered under this ***Plan*** when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

The ***Plan*** shall not be deemed to constitute a contract between the ***employer*** and any ***employee*** or to be a consideration for, or an inducement or condition of, the employment of any ***employee.*** Nothing in the ***Plan*** shall be deemed to give any ***employee*** the right to be retained in the service of the ***employer*** or to interfere with the right of the ***employer*** to terminate the employment of any ***employee*** at any time.

PLAN MODIFICATION AND AMENDMENT

The ***employer*** may modify or amend the ***Plan*** from time to time at its sole discretion, and such amendments or modifications which affect ***covered persons*** will be communicated to the ***covered persons.*** Any such amendments shall be in writing, setting forth the modified provisions of the ***Plan,*** the ***effective date*** of the modifications, and shall be signed by the ***employer's*** designee.

An amendment to the ***Plan*** may be retroactively effective, but shall not adversely affect the rights of ***covered persons*** under this ***Plan*** for ***covered expenses*** provided after the effective date of the amendment but before the amendment is adopted.

Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***employer,*** or a written copy thereof shall be deposited with such master copy of the ***Plan.***

PLAN TERMINATION

The ***employer*** reserves the right to terminate the ***Plan,*** in whole or in part, at any time. Upon termination, the rights of the ***covered persons*** to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the ***Plan*** will be communicated to the ***covered persons.***

Upon termination of this ***Plan,*** all claims ***incurred*** prior to termination, but not submitted to either the ***employer*** or ***claims processor*** within three (3) months of the ***effective date*** of termination of this ***Plan,*** will be excluded from any benefit consideration.

PRIVACY RULE

It is intended for the ***Plan*** to be in compliance with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504 (f) is referred to as "the 504" provisions") by establishing the extent to which the ***Plan sponsor*** will receive, use and /or disclose Protected Health Information (PHI).

Designation Of Person/Entity To Act On Plan's Behalf

The ***Plan*** has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the ***Plan*** designates the Human Resources Manager to take all actions required to be taken by the ***Plan*** in connection with the HIPAA Privacy Rule.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor – Required Certification of Compliance by Plan Sponsor

1. Except as provided below with respect to the ***Plan's*** disclosure of summary health information, the ***Plan*** will (a) disclose PHI to the ***Plan Sponsor*** or (b) provide for or permit the disclosure of PHI to the ***Plan Sponsor*** by the ***claims processor*** with respect to the ***Plan***, *only if* the ***Plan*** has received a certification (signed on behalf of the ***Plan Sponsor***) that:

    A. The Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the ***Plan Sponsor***;

    B. The ***Plan Sponsor*** agrees to comply with the ***Plan*** provisions in relation to HIPAA Privacy Rules.

Permitted Disclosure of Individuals' Protected Health Information (PHI) to the Plan Sponsor

1. The ***Plan*** (and any business associates acting on behalf of the ***Plan***), or any health insurance issuer servicing the ***Plan*** will disclose individuals' PHI to the ***Plan Sponsor*** only to permit the ***Plan Sponsor*** to carry out plan administration functions.

2. All disclosures of the PHI of the ***Plan's covered persons*** by the ***Plan's*** business associate, or health insurance issuer to the ***Plan Sponsor*** will comply with the restrictions and requirements set forth herein.

3. The ***Plan*** (and any business associate acting on behalf of the ***Plan***), may not, and may not permit a health insurance issuer to, disclose individuals' PHI to the ***Plan Sponsor*** for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the ***Plan Sponsor***.

4. The ***Plan Sponsor*** will not use or further disclose individuals' PHI other than as described in the Plan Documents.

5. The ***Plan Sponsor*** will ensure that any agent(s), including a subcontractor, to whom it provides individuals' PHI received from the ***Plan*** (or from the ***Plan's*** health insurance issuer), agrees to the same restrictions and conditions that apply to the ***Plan Sponsor*** with respect to such PHI.

6. The ***Plan Sponsor*** will not use or disclose individuals' PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the ***Plan Sponsor.***

7. The ***Plan Sponsor*** will report to the **Plan** any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Plan Document of which the ***Plan Sponsor*** becomes aware.

Disclosure of Individuals' Protected Health Information - Disclosure by the Plan Sponsor

1. The ***Plan Sponsor*** will make the PHI of the individual who is the subject of the PHI available to such individual.

2. The ***Plan Sponsor*** will make individuals' PHI available for amendment and incorporate any amendments to individuals' PHI.

3. The ***Plan Sponsor*** will make and maintain an accounting so that it can make available those disclosures of individuals' PHI.

4. The ***Plan Sponsor*** will make its internal practices, books and records relating to the use and disclosure of individuals' PHI received from the ***Plan*** available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

5. The ***Plan Sponsor*** will, if feasible, return or destroy all individuals' PHI received from the Plan (or a health insurance with respect to the Plan) that the ***Plan Sponsor*** still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the ***Plan Sponsor*** will not retain copies of such PHI after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the ***Plan Sponsor*** will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

6. The ***Plan Sponsor*** will ensure that the required adequate separation, described below, is established and maintained.

Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

1. The **Plan**, or a health insurance issuer with respect to the **Plan**, may disclose summary health information to the ***Plan Sponsor*** if the ***Plan Sponsor*** requests the summary health information for the purpose of:

    A. Obtaining premium bids from health plans for providing health insurance coverage under the ***Plan;*** or

    B. Modifying, amending, or terminating the ***Plan.***

2. The ***Plan***, or a ***claims processor*** with respect to the ***Plan***, may disclose enrollment and disenrollment information to the ***Plan Sponsor.***

Required Separation Between the Plan and the Plan Sponsor

1. This section describes the employees or classes of employees or workforce members under the control of

the ***Plan Sponsor*** who may be given access to individuals' PHI received from the ***Plan*** or from the ***claims processor*** servicing the ***Plan***: Insurance Manager

2. This list reflects the employees, classes of employees or other workforce members of the ***Plan Sponsor*** who receive individuals' PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the ***Plan Sponsor*** provides for the ***Plan***. These individuals will have access to individuals' PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the ***Plan Sponsor***) for any use or disclosure of individuals' PHI in violation of, or noncompliance with, the provisions herein.

PRONOUNS

All personal pronouns used in this ***Plan*** shall include either gender unless the context clearly indicates to the contrary.

RECISSION OF COVERAGE

Notwithstanding the provisions for termination of coverage as provided within the section entitled, *Termination of Coverage,* or the retroactive termination of coverage as provided within the section entitled, *General Provisions, Misrepresentation,* should the ***Plan*** determine that a ***covered person's*** coverage hereunder should be terminated, the ***covered person's*** shall be sent a written notice of the effective date of termination of coverage to the last known address of the ***covered person***. Said notice shall be a minimum of thirty (30) calendar days prior to the effective date of termination.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the ***Plan*** in excess of the maximum amount of payment necessary, the ***Plan*** will have the right to recover these excess payments. If the company makes any payment that, according to the terms of the ***Plan,*** should not have been made, the ***Plan*** may recover that incorrect payment, whether or not it was made due to the Company's own error, from the person or entity to whom it was made or from any other appropriate party.

SECURITY RULES

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the ***Plan Sponsor*** on behalf of the ***Plan,*** the ***Plan Sponsor*** shall reasonably safeguard the Electronic Protected Health Information as follows:

1. ***Plan Sponsor*** shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that ***Plan Sponsor*** creates, receives, maintains, or transmits on behalf of the ***Plan***;

2. ***Plan Sponsor*** shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

3. ***Plan Sponsor*** shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

4. ***Plan Sponsor*** shall report to the ***Plan*** any ***Security Incidents*** of which it becomes aware as described below:

    A. ***Plan Sponsor*** shall report to the ***Plan*** within a reasonable time after ***Plan Sponsor*** becomes aware, any ***Security Incident*** that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

B. ***Plan Sponsor*** shall report to the ***Plan*** any other ***Security Incident*** on an aggregate basis every quarter, or more frequently upon the ***Plan's*** request.

STATUS CHANGE

If an ***employee*** or ***dependent*** has a status change while covered under this ***Plan*** (i.e. ***dependent*** to ***employee,*** COBRA to Active) and no interruption in coverage has occurred, the ***Plan*** will provide continuance of coverage with respect to any ***preexisting condition*** limitation, deductible(s), ***coinsurance*** and ***maximum benefit.***

TIME EFFECTIVE

The effective time with respect to any dates used in the ***Plan*** shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the ***Plan administrator.***

WORKERS' COMPENSATION NOT AFFECTED

This ***Plan*** is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document:

Administrative Period

The ***administrative period*** is the period of time used by the ***employer*** to assess an ***employee's*** eligibility for coverage under the ***Plan,*** prepare and distribute enrollment materials, and allow time for ***employee*** submission. The ***administrative period*** for new hire ***employees*** shall be two (2) ***calendar months*** starting with the calendar day after the last calendar day of a ***measurement period.*** The ***administrative period*** for ***ongoing employees*** shall be sixty (60) day period of time starting with the calendar day after the last calendar day of a ***measurement period.*** The ***administrative period*** for ***ongoing employees*** shall be two (2) ***calendar months*** of time starting with the calendar day after the last calendar day of a ***measurement period.***

Alternate Recipient

Any child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan.***

Ambulatory Surgical Facility

A ***facility*** provider with an organized staff of ***physicians*** which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc. or by the ***Plan,*** which:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;

2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***covered person*** is in the ***ambulatory surgical facility;***

3. Does not provide ***inpatient*** accommodations; and

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a ***physician.***

Approved Clinical Trials

A Phase 1, 2, 3 or 4clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is one (1) of the following:

1. a federally funded or approved trial;

2. a clinical trial conducted under an FDA investigational new drug application;

3. a drug trial that is exempt from the requirement of an FDA investigational new drug application.

Benefit Year

The twelve-month period of January 1st through December 31st for which all ***Plan*** benefits shall be calculated. Any applicable deductible, out-of-pocket maximum expense limit, or ***maximum benefits*** shall accrue on a ***benefit year*** basis.

Birthing Center

A ***facility*** that meets professionally recognized standards and all of the following tests:

1. It mainly provides an ***outpatient*** setting for childbirth following a normal, uncomplicated ***pregnancy,*** in a home-like atmosphere.

2. It has: (a) at least two (2) delivery rooms; (b) all the medical equipment needed to support the services furnished by the facility; (c) laboratory diagnostic facilities; and (d) emergency equipment, trays, and supplies for use in life threatening situations.

3. It has a medical staff that: (a) is supervised full-time by a ***physician;*** and (b) includes a registered nurse at all times when ***covered persons*** are at the facility.

4. If it is not part of a ***hospital,*** it has written agreement(s) with a local ***hospital(s)*** and a local ambulance company for the immediate transfer of ***covered persons*** who develop complications or who require either pre or post-natal care.

5. It admits only ***covered persons*** who: (a) have undergone an educational program to prepare them for the birth; and (b) have medical records of adequate prenatal care.

6. It schedules ***confinements*** of not more than twenty-four (24) hours for a birth.

7. It maintains medical records for each ***covered person.***

8. It complies with all licensing and other legal requirements that apply.

9. It is not the office or clinic of one or more physicians or a specialized facility other than a birthing center.

Break in Service

A period of at least thirteen (13) consecutive ***weeks*** during which the ***employee*** has no ***hours of service*** for the ***employer.*** A ***break in service*** may also include any period for which the ***employee*** has no ***hours of service*** that is at least four (4) consecutive ***weeks*** in duration and longer than the prior period of employment as determined after application of the procedures applicable to ***special unpaid leaves***.

Calendar Month

One of the twelve (12) months named in the calendar (e.g. January, February, etc.).

Case Management

A program of medical management typically utilized in situations involving extensive and on-going medical treatment, which provides a comprehensive and coordinated delivery of services under the oversight of a medically responsible individual or agency. Such programs may provide benefits not normally covered under ***Plan*** provisions in lieu of ***inpatient hospital*** treatment.

Chemical Dependency

A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria.

Chiropractic Care

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claims Processor

The company contracted by the ***employer*** which is responsible for the processing of claims for benefits under the terms of the ***Plan*** and other ministerial services deemed necessary for the operation of the ***Plan*** as delegated by the ***employer.***

Close Relative

The ***employee's*** spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the ***employee's*** spouse.

Coinsurance

The benefit percentage of ***covered expenses*** payable by the ***Plan*** for benefits that are provided under the ***Plan.*** The ***coinsurance*** is applied to ***covered expenses*** after the deductible(s) have been met, if applicable.

Complications of Pregnancy

A disease, disorder or condition which is diagnosed as distinct from ***pregnancy,*** but is adversely affected by or caused by ***pregnancy.*** Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).

2. Ectopic ***pregnancy.***

3. Toxemia with convulsions (Eclampsia).

4. Pernicious vomiting (hyperemesis gravidarum).

5. Nephrosis.

6. Cardiac Decompensation.

7. Missed Abortion.

8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during ***pregnancy*** even if prescribed by a ***physician;*** morning sickness; or like conditions that are not medically termed as ***complications of pregnancy.***

Concurrent Review

A review by the ***Utilization Review Organization*** which occurs during the ***covered person's hospital confinement*** to determine if continued ***inpatient*** care is ***medically necessary.***

Confinement

A continuous stay in a ***hospital, treatment center, extended care facility, hospice,*** or ***birthing center*** due to an ***illness*** or ***injury*** diagnosed by a ***physician.*** Later stays shall be deemed part of the original ***confinement*** unless there was either complete recovery during the interim from the ***illness*** or ***injury*** causing the initial stay, or unless the latter stay results from a cause or causes unrelated to the ***illness*** or ***injury*** causing the initial stay.

Copay

A cost sharing arrangement whereby a ***covered person*** pays a set dollar amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery, Cosmetic Treatment

Surgery or treatment for the restoration, repair, or reconstruction of body structures directed toward, or resulting in, improvement or preservation of physical appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to an ***illness*** or ***injury***.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a ***physician, professional provider*** or covered ***facility*** for the treatment of an ***illness*** or ***injury*** and that are not specifically excluded from coverage herein. ***Covered expenses*** shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under this ***Plan,*** or becomes eligible at a later date, and for whom the coverage provided by this ***Plan*** is in effect.

Custodial Care

Care provided primarily for maintenance of the ***covered person*** or which is designed essentially to assist the ***covered person*** in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an ***illness*** or ***injury.*** ***Custodial care*** includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered ***custodial care*** without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered ***custodial care*** (1) if provided during ***confinement*** in an institution for which coverage is available under this ***Plan,*** and (2) if combined with other necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the ***covered person's*** medical condition.

Customary and Reasonable Amount

Customary and reasonable amount shall mean ***covered expenses*** which are identified by the ***claims processor,*** taking into consideration the fee(s) which the provider of service most frequently charges the majority of patients for the service or supply; the amount the provider of service accepts from others as payment for the service or supply; the amount the provider of service accepts from others as payment for the service or supply; the cost to the provider of service for providing the service; the prevailing range of fees charged in the same "area" by providers of service of similar training and experience for the service or supply; and the ***Medicare*** reimbursement rates. The ***customary and reasonable amount*** shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross section of providers of service, persons or organizations rendering such treatment, services or supplies for which a specific charge is made.

Dentist

A licensed doctor of dental medicine (D.M.D.) or a licensed doctor of dental surgery (D.D.S.), other than a ***close relative*** of the ***covered person.***

Dependents

For a complete definition of ***dependent,*** refer to *Eligibility, Dependent Eligibility.*

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;

2. Is primarily and customarily used to serve a medical purpose;

3. Is generally not used in the absence of an ***illness*** or ***injury;***

4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered ***durable medical equipment. Durable medical equipment*** includes, but is not limited to: crutches, wheel chairs, ***hospital*** beds, etc.

Effective Date

The date of this ***Plan*** or the date on which the ***covered person's*** coverage commences, whichever occurs later.

Electronic Protected Health Information

The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

Emergency

A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in one or more of the following:

1. Placing the health of the ***covered person*** (or with respect to a pregnant woman, the health of the woman or her unborn fetus) in serious jeopardy, or

2. Serious impairment to bodily functions, or

3. Serious dysfunction of any bodily organ or part, or

With respect to a pregnant woman having contractions:

1. That there is inadequate time to effect a safe transfer to another hospital before delivery, or

2. That transfer may pose a threat to the health or safety of the woman or the unborn child.

Employee, or ***Regular Employee***

For a complete definition of employee, refer to *Eligibility, Employee Eligibility.* Such term shall not include individuals classified by the ***employer*** as independent contractors (including any person who later becomes reclassified as an ***employee*** by the Internal Revenue Service or a court of competent jurisdiction). For purposes of this document, any individual who pays or agrees to pay self-employment tax in lieu of withholding shall be deemed to be an independent contractor, not an ***employee.***

Employer

The ***employer*** is Blackwater Community School.

Enrollment Date

A ***covered person's enrollment date*** is the first day of any applicable service waiting period or the date of hire.

Experimental/Investigational

Services, supplies, and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The ***Plan administrator*** must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The ***Plan administrator*** shall be guided by a reasonable interpretation of ***Plan*** provisions. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The ***Plan administrator*** will be guided by the following principles:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment or procedure, or the ***covered person*** informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

3. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an ***inpatient*** basis, for persons convalescing from ***illness*** or ***injury,*** professional nursing services, and physical restoration services to assist ***covered persons*** to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a registered nurse.

2. Its services are provided for compensation from its ***covered persons*** and under the full-time supervision of a ***physician*** or Registered Nurse.

3. It provides twenty-four (24) hour a day nursing services.

4. It maintains a complete medical record on each ***covered person.***

5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of ***mental and nervous disorders.***

6. It is approved and licensed by ***Medicare.***

This term shall also apply to expenses ***incurred*** in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

Facility

A healthcare institution which meets all applicable state or local licensure requirements, such as a freestanding dialysis ***facility,*** a lithotriptor center or an outpatient imaging center.

Full-time

A common law ***employee*** who is regularly scheduled to work thirty (30) ***hours of service*** or more per week.

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

Hours of Service

Each hour for which the ***employee*** is paid or entitled to payment for performance of services for the ***employer*** AND any hour for which the ***employee*** is paid or entitled to payment by the ***employer*** for a period of time during which no duties are performed due to any of the following:

- Vacation
- Holiday
- Illness or incapacity
- Layoff
- Jury duty
- Military duty or leave of absence

Home Health Aide Services

Those services which may be provided by a person, other than a Registered Nurse, which are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.

2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered Nurse. It must provide for full-time supervision of such services by a ***physician*** or Registered Nurse.

3. It maintains a complete medical record on each ***covered person.***

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under ***Medicare.***

Hospice

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.

2. It provides service twenty-four (24) hours per day, seven (7) days a week.

3. It is under the direct supervision of a ***physician.***

4. It has a Nurse coordinator who is a Registered Nurse.

5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of ***hospice*** services.

7. It has a full-time administrator.

8. It maintains written records of services provided to the ***covered person.***

9. It is licensed, if licensing is required.

Hospital

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals.***

2. It is engaged primarily in providing medical care and treatment to ***ill*** and ***injured*** persons on an ***inpatient*** basis at the ***covered person's*** expense.

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury;*** and such treatment is provided by or under the supervision of a ***physician*** with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.

4. It qualifies as a ***hospital*** and is accredited by The Joint Commission on the Accreditation of Healthcare Organizations.

5. It must be approved by ***Medicare.***

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a facility designed exclusively for rehabilitative services where the ***covered person*** received treatment as a result of an ***illness*** or ***injury.***

The term ***hospital,*** when used in conjunction with ***inpatient confinement*** for mental and nervous conditions or ***chemical dependency,*** will be deemed to include an institution which is licensed as a mental ***hospital*** or ***chemical dependency*** rehabilitation and/or detoxification ***facility*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Illness

A bodily disorder, disease, or physical sickness. ***Pregnancy*** of a covered ***employee*** or their covered spouse shall be considered an ***illness.***

Incurred or Incurred Date

With respect to a ***covered expense,*** the date the services, supplies or treatment are provided.

Initial Measurement Period

The twelve (12) ***calendar month*** period beginning on the first day of the ***calendar month*** coinciding with or next following the ***employee's*** date of hire. Notwithstanding the foregoing, the ***employer*** may make adjustments to the ***standard measurement period*** with respect to ***employees*** on payroll periods that are weekly, bi-weekly or semi-monthly in duration.

Injury

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound, or self-inflicted ***injury.***

Inpatient

A ***confinement*** of a ***covered person*** in a ***hospital, hospice,*** or ***extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board.***

Intensive Care

A service which is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance which is prescribed by the attending ***physician.***

Intensive Care Unit

A separate, clearly designated service area which is maintained within a ***hospital*** solely for the provision of ***intensive care.*** It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital;***

2. Special life saving equipment which is immediately available at all times;

3. At least two beds for the accommodation of the critically ill; and

4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours per day.

This term does not include care in a surgical recovery room.

Late Enrollee

A ***covered person*** who did not enroll in the ***Plan*** when first eligible or as the result of a Special Enrollment Period.

Layoff

A period of time during which the ***employee,*** at the ***employer's*** request, does not work for the ***employer,*** but which is of a stated or limited duration and after which time the ***employee*** is expected to return to ***full-time, active work.*** Layoffs will otherwise be in accordance with the ***employer's*** standard personnel practices and policies.

Life-threatening Condition

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Leave of Absence

A period of time during which the ***employee*** does not work, but which is of stated duration after which time the ***employee*** is expected to return to active work***.***

Maximum Benefit

Any one of the following, or any combination of the following:

1. The maximum amount paid by this ***Plan*** for any one ***covered person*** for a particular ***covered expense.*** The maximum amount can be for:

   A. The entire time the ***covered person*** is covered under this ***Plan,*** or
   B. A specified period of time, such as a ***benefit year***.

2. The maximum number the ***Plan*** acknowledges as a ***covered expense.*** The maximum number relates to the number of:

   A. Treatments during a specified period of time, or
   B. Days of ***confinement,*** or
   C. Visits by a ***home health care agency.***

Measurement Period

The ***initial measurement period*** or the ***standard measurement period***, as applicable to the Look Back ***measurement period*** method. For the monthly ***measurement period*** method, the ***calendar month.***

Medically Necessary (Medical Necessity)

Service, supply or treatment which, as determined by the ***employer/Plan administrator***, to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered;

2. In accordance with current standards of good medical practice within the organized medical community and is medically proven to be effective treatment of the ***illness*** or ***injury;***

3. The most appropriate supply or level of service that can safely be provided to the ***covered person.*** When applied to an ***inpatient*** admission, this further means that the ***covered person*** requires acute care as a bed patient due to the nature of the services rendered or the ***covered person's illness*** or ***injury,*** and the ***covered person*** cannot receive safe or adequate care as an ***outpatient.***

A service, supply, or treatment will not be considered ***medically necessary*** if:

1. It is provided only as a convenience to the ***covered person*** or provider;

2. It is part of a plan of treatment that is experimental, unproven, or related to research protocol.

The fact that a ***physician*** may prescribe, order, recommend, perform, or approve a service, supply or treatment does not, in and of itself, make the service, supply, or treatment ***medically necessary.*** In making the determination of whether a service or supply was ***medically necessary,*** the ***employer/Plan administrator***, or its designee, may request and rely upon the opinion of a ***physician*** or ***physicians.*** The determination of the ***employer/Plan administrator*** shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; and Part C, Miscellaneous provisions regarding both programs; and including any subsequent changes or additions to those programs.

Mental and Nervous Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Month

The period that begins on any date following the first day of a ***calendar month*** and that ends on the immediately preceding date in the immediately following ***calendar month*** (for example, from February 2 to March 1 or from December 15 to January 14).

Negotiated Rate

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan.***

New Employee Stability Period

The twelve (12) ***calendar month*** period that begins on the first calendar day after the end of the ***administrative period,*** as it applies to the Look Back ***measurement period*** method.

Nonparticipating Pharmacy

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a ***participating pharmacy.***

Nonpreferred Provider

A ***physician, hospital,*** or other health care provider which does not have an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

Nurse

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) who is practicing within the scope of the license.

Ongoing Employee

An ***employee*** who has been employed by the ***employer*** for at least one complete ***standard measurement period,*** as it applies to the Look Back ***measurement period*** method.

Ongoing Employee Stability Period

The twelve (12) ***calendar month*** period that begins on the first day of the ***calendar month*** following the end of the ***administrative period,*** as it applies to the Look Back ***measurement period*** method.

Outpatient

A ***covered person*** shall be considered to be an ***outpatient*** if he is treated at:

1. A ***hospital*** as other than an ***inpatient;***

2. A ***physician's*** office, laboratory or x-ray ***facility;*** or

3. An ***ambulatory surgical facility;*** and

The stay is less than twenty-three (23) consecutive hours.

Partial Confinement

A period of less than twenty-four (24) hours of active treatment in a ***facility*** licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services;

2. Treatment of ***mental and nervous disorders.***

3. Alcoholism treatment;

4. ***Chemical dependency*** treatment;

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs, which is contracted within the pharmacy organization.

Physician

A person duly licensed to practice medicine, to prescribe and administer drugs, or to perform surgery. This definition includes a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), Dentists, Podiatrists, Chiropractors, Psychologists and Psychiatrists provided that each, who is practicing within the scope of his license, is permitted to perform services covered under this ***Plan*** and that this ***Plan*** does not exclude the services provided by such ***physician.***

Placed For Adoption

The date the ***employee*** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"Plan" refers to the benefits and provisions for payment of same as described herein.

Plan Administrator

The ***Plan administrator*** is responsible for the day-to-day functions and management of the ***Plan.*** The ***Plan administrator*** is the ***employer.***

Plan Documents

The ***Plan's*** governing document and instruments (i.e., the documents under which the group health plan was established and is maintained).

Plan Sponsor

The ***Plan sponsor*** is the ***employer.***

Preferred Provider

A ***physician, hospital*** or other health care ***facility*** who has an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered. ***Preferred providers*** agree to accept the ***negotiated rate*** as payment in full.

Preferred Provider Organization

An organization who selects and contracts with certain ***hospitals, physicians,*** and other health care providers to provide ***covered persons*** services, supplies and treatment at a ***negotiated rate.***

Pregnancy

The physical state which results in childbirth or miscarriage.

Primary Care Physician

General practitioner, family practice, internal medicine, OB/GYN, and pediatrician

Charges from Nurse Practitioners (N.P.) and Physician's Assistants (P.A.) will be considered at the level of the provider they bill under.

Professional Provider

A person or other entity licensed where required and performing services within the scope of such license. The covered ***professional providers*** include, but are not limited to:

Audiologist
Certified Addictions Counselor
Certified Registered Nurse Anesthetist
Certified Registered Nurse Practitioner
Chiropractor
Clinical Laboratory
Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)
Dietician
Dispensing optician
Midwife
Nurse (R.N., L.P.N., L.V.N.)
Occupational Therapist
Optician
Optometrist
Physical Therapist
Physician
Physician's Assistant
Podiatrist
Psychologist

Respiratory Therapist
Speech Therapist

Qualifying Part-time Employee

For a complete definition of ***qualifying part-time employee***, refer to the section entitled, *Eligibility, Employee Eligibility.*

Reconstructive Surgery

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Retrospective Review

A review by the ***Utilization Review Organization*** after the ***covered person's*** discharge from ***hospital confinement*** to determine if, and to what extent, ***inpatient*** care was ***medically necessary.***

Room and Board

Room and linen service, dietary service, including meals, ***medically necessary*** special diets and nourishments, and general nursing service. ***Room and board*** does not include personal items.

Seasonal Employee

An ***employee*** hired by the ***employer*** into a position that is expected to average thirty (30) hours or more per ***week***, but typically no longer in duration than six (6) months and begins at the same time of the year each year.

Semiprivate

The daily ***room and board*** charge which a ***facility*** applies to the greatest number of beds in its ***semiprivate*** rooms containing two (2) or more beds.

Security Incidents

The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system. For the purpose of the ***Plan Sponsor's*** requirement to report any ***Security Incidents***, only successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system shall be included.

Special Unpaid Leave of Absence

Any of the following types of unpaid leaves of absence that do not constitute a ***break in service***: (i) Leave protected by the Family and Medical Leave Act, (ii) leave protected by the Uniformed Services Employment and Reemployment Rights Act or (iii) Jury Duty (as reasonably defined by the ***employer***).

Standard Measurement Period

As it applies to the Look Back ***measurement period*** method, the twelve (12) ***month*** period that begins each May 1st and ends April 30th. Notwithstanding the foregoing, the ***employer*** may make adjustments to the ***standard measurement period*** with respect to ***employees*** on payroll periods that are weekly, bi-weekly or semi-monthly in duration.

Total Disability or Totally Disabled

The ***employee*** is prevented from engaging in his regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a ***dependent*** is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.

Treatment Center

1. An institution which does not qualify as a ***hospital,*** but which does provide a program of effective medical and therapeutic treatment for ***chemical dependency,*** and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:

    A. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
    B. It provides a program of treatment approved by the ***physician.***
    C. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person.***
    D. It provides at least the following basic services:
        (1) ***Room and board***
        (2) Evaluation and diagnosis
        (3) Counseling
        (4) Referral and orientation to specialized community resources.

Urgent Care

A claims involving ***urgent care*** is generally a claim for medical care or treatment with respect to which the application of the time periods for making the non-urgent care determinations could seriously jeopardize the life or health of the ***covered person*** or the ability of the ***covered person*** to regain maximum function; or, in the opinion of the ***physician*** with knowledge of the ***covered person's*** medical condition, would subject the ***covered person*** to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Utilization Review

A process of evaluating if services, supplies or treatment are ***medically necessary*** to help ensure cost-effective care.

Utilization Review Organization

The individual or organization designated by the ***employer*** for the process of evaluating whether the service, supply, or treatment is ***medically necessary.***

Week

Any seven (7) consecutive ***calendar***-day period.