CARMEL CENTRAL SCHOOL DISTRICT
PATTERSON, NY

HEALTH BENEFITS PLAN

Revised 06-22-2023

The benefits described in this Plan Document are the product of collective bargaining agreements between the Carmel Central School District and the various bargaining units representing the employees of the Carmel Central School District. In addition, benefits and member eligibility have been altered from those negotiated as a result of Federal legislation. It is the intention of the Carmel Central School District Health Benefits Plan to comply with all legal requirements. In the event that some requirement has not been specifically written into this Plan Document, the requirement will nonetheless be met. Future changes in legislation may remove requirements to provide benefits or member eligibility, which have not otherwise been negotiated. In such cases, mandated changes will be rescinded. Benefits and member eligibility will return to those in place prior to the legislation.

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CARMEL CENTRAL SCHOOL DISTRICT

GROUP HEALTH BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

Effective: 01-01-2019

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under this Plan as well as information on a Covered Person's rights and obligations under the CARMEL CENTRAL SCHOOL DISTRICT Health Benefits Plan (the "Plan"). As a valued Employee of CARMEL CENTRAL SCHOOL DISTRICT, we are pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions.

CARMEL CENTRAL SCHOOL DISTRICT is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are identified in Appendix D for medical claims and for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits.

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in the Glossary of Terms, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Glossary will help to better understand the provisions of this Plan.

Individuals covered under this Plan will be receiving an identification card to present to the provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

This document summarizes the benefits and limitations of the Plan and is known as a Summary Plan Description ("SPD").

This document becomes effective on January 1, 2019.

欲将该文件翻译成中文，请联系您的雇主。

Díí naaltsos Dine k'eh saadjį'go háádidool nilgo, éí t'ááshǫǫdí bá nalnishígíí bil hodolnih.

Si necesita este documento traducido al español, comuníquese con su empleador.

Upang ipa-translate ang dokumentong ito sa Tagalog, mangyaring makipag-ugnay sa iyong employer.

PLAN INFORMATION

Plan Name	CARMEL CENTRAL SCHOOL DISTRICT GROUP BENEFIT PLAN
Name And Address Of Employer	CARMEL CENTRAL SCHOOL DISTRICT CENTRAL OFFICE 81 SOUTH ST PATTERSON NY 12563
Name, Address And Phone Number Of Plan Administrator	CARMEL CENTRAL SCHOOL DISTRICT CENTRAL OFFICE 81 SOUTH ST PATTERSON NY 12563 845-878-2094 EXT 212
Named Fiduciary	CARMEL CENTRAL SCHOOL DISTRICT
Employer Identification Number Assigned By The IRS	14-6001296
Type Of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. The claims administrators identified in Appendix D provide administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	ASSISTANT SUPERINTENDENT FOR BUSINESS CARMEL CENTRAL SCHOOL DISTRICT CENTRAL OFFICE 81 SOUTH ST PATTERSON NY 12563 Services of legal process may also be made upon the Plan Administrator.
Funding Of The Plan	Employer and Employee Contributions Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.
Collective Bargaining Provisions	The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of the agreements may be obtained upon written request to the Plan Administrator, and such agreements are available for examination.
Benefit Plan Year	Benefits begin on January 1 and ends on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
FISCAL Plan Year	July 1 through June 30

Compliance

It is intended that this Plan meet all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles or out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

If two or more covered family members are injured in the same Accident, only one Deductible needs to be met for those Covered Expenses which are due to that Accident, and Incurred during that calendar year.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown in Appendix B, Schedule of Benefits. The Patient Protection and Affordable Care Act provides for Individual and Family Out-of-Pocket Maximums that change annually. Those amounts are also identified in Appendix B. Amounts the Covered Person incurs for Covered Expenses, such as any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). Pharmacy expenses that the Covered Person incurs do not apply toward the out-of-pocket maximum of this Plan.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Individual and family Deductibles.
- Expenses for Mental Health Disorders for outpatient treatment.

- Expenses for substance abuse and chemical dependency for outpatient treatment.
- Expenses Incurred as a result of failure to comply with prior authorization requirements for Hospital confinement.
- Any amounts over the Usual and Customary amount, Negotiated Rate or established fee schedule that this Plan pays.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any "fee forgiveness", "not out-of-pocket" or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. The Plan may request documentation from You or Your dependents in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

ELIGIBILITY REQUIREMENTS

Rules concerning eligibility for Plan enrollment are established by collective bargaining agreements and by established policies of the Carmel School District Board of Education, as Amended. The content in this section is not intended to constitute, or be validated as, the origin or basis for Plan eligibility requirements. The District Benefits Office can provide full details of the District's current eligibility requirements for Plan enrollment.

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works at least the qualifying hours per week based on criteria established by the District or by negotiated bargaining agreements with the District, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Temporary or leased employees.
- An Independent Contractor who signs an agreement with the employer as an Independent Contractor or other Independent Contractors as defined in this document.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis.

An eligible Employee who is covered under this Plan and who retires under the employer's formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution. See the Coordination of Benefits section for more information on how this Plan coordinates with Medicare coverage.

An **eligible Dependent** includes:

- Legal Spouse of an Employee or retiree. (A legally separated Spouse may be enrolled in the Plan, but a divorced Spouse is not eligible). The District requires proof of marriage and/or divorce.

- A Dependent Child that resides in the United States until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents:

    - A natural biological Child;
    - A step Child;

- Any unmarried Child placed for adoption before the Child reaches age 26 The term placed for adoption means a Child placed in the Employee/Retiree's home and the Employee/Retiree's assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of the Child. This eligibility ends when such legal obligation terminates. Proof of pre-adoption status will be required by the District Benefits Office to establish eligibility. Once the Child is legally adopted, he or she retains eligibility as a legally adopted Child as shown above.
- Pre-adoptive newborn from the moment of birth under family coverage when all of the following conditions are met:
  - You enroll the Child, you intend to adopt, in family coverage within 30 days of the birth and applicable family contribution is made;
  - You take physical custody of the Child upon her or his discharge from the hospital or birth center; and
  - Within 30 days of the Child's birth, You file a petition to adopt or for temporary legal guardianship under New York State Domestic Relations Law or similar state laws when filed outside NY state. Coverage will not be provided for initial inpatient treatment of a pre-adoptive newborn, if the Child's biological parent has health coverage for that care. Also, if a notice of revocation of the adoption has been filed, or a biological parent revokes consent to the adoption, Plan coverage will not be provided. If Plan benefits were paid for a pre-adoptive newborn, whose adoption was revoked, the Employee/Retiree may be requested to reimburse those Plan payments.
- A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO).
- Any other Child supported by the Employee/Retiree or the spouse of the Employee/Retiree and permanently residing in the Employee/Retiree's home, provided the support and residence commenced before the child reached age 26.

Coverage will not be provided for initial Inpatient treatment of a pre-adoptive newborn, if the child's biological parent has health coverage for that care. Also, if a notice of revocation of the adoption has been filed, or a biological parent revokes consent to the adoption, Plan Coverage will not be provided. If Plan benefits were paid for a pre-adoptive newborn, whose adoption was revoked, the Employee/retiree may be requested to reimburse those Plan payments.

Please Note

Documentation of the Dependent status with the District Benefits Office will be required. Criteria of support will be deemed to have been met if the Employee contributes at least 50 percent to the support of the Dependent and that Dependent qualifies as an exemption on the most recent Federal income tax return filed by the Employee.

- A Dependent does not include the following:

  - A Dependent Child if the Child is covered as a Dependent of another Employee at this company.
  - A Child of a Domestic partner or under Your Domestic Partner's Legal Guardianship;
  - Domestic Partners.

Employees have the right to choose which eligible Dependents are covered under the Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have a notice obligation to notify the Plan should the Dependent's eligibility status change throughout the Plan year. Please notify Your Human Resources Department regarding status changes.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of:

- If you enroll at the time of eligible employment, Plan Coverage begins on the first day of the month following the date of eligible employment.

- If you fail to enroll within 30 days of eligible employment, Coverage begins no sooner than the first day of the month following the date the District Benefits Office accepts your late enrollment application.

- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 30 days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 30 days of acquiring the Dependent; or
- The first day of the month following the date an enrollment application is properly made if the Dependent is a Late Enrollee. The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 30 days of Your hire date, or more than 30 days following the date You acquire the Dependent; or
- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 30 days following the event; or
- The later of the date specified in a Qualified Medical Child Support Order or the date the plan administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent, if additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PROVISION

During the annual open enrollment period, eligible Employees and Retirees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Eligible Employees and their Dependents who enroll during the annual open enrollment period will be considered Late Enrollees. Covered Employees and covered Retirees will be able to make a change in coverage for themselves and their eligible Dependents.

Coverage Waiting Periods and Pre-Existing Condition Limits are waived during the annual open enrollment period for covered Employees, covered Retirees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent become covered under this Plan as a result of electing coverage during the annual open enrollment period, the following shall apply:

- Dependents will become effective on the date the Employee becomes covered if the Employee requests coverage for such Dependent when enrolling in the Plan. If you fail to enroll an existing eligible Dependent at the time of your initial enrollment, you may apply during the bi-annual open enrollment period to occur during October and May for the current school year, and the annual open enrollment period to occur in October for the current school year. During this period eligible Employees may elect to change coverage (individual to family, or family to individual) without having to meet any other special enrollment qualifiers. The effective date for this coverage will be the first day of the month following the open enrollment period. Late enrollment can only be made during the Plan’s open enrollment period except as described under “Special Enrollment Provision”.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

Effective: 04-01-2009

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

Note: Retirees are not eligible for special enrollment due to loss of other coverage. Similarly, Retirees who are not currently participating in the Plan will not be eligible to enroll upon acquisition of a new Dependent.

Survivor Dependent Eligibility

Should you die, your enrolled Dependents should contact the District Benefits Office for complete details concerning eligibility and costs for Coverage under this rule.

If an active Employee or retiree dies, his or her survivor Dependents who are enrolled in his or her family Coverage could be eligible for survivor enrollment. This extension of eligibility continues to apply to survivors of eligible retirees or survivors of eligible Employees. To be covered, the survivors must request enrollment within 90 days after the death of the Employee or retiree and pay designated participation costs. If enrollment is not made within 90 days, eligibility under this rule is not available. This Coverage ends for the Spouse and dependent children when the survivor spouse remarries. For survivor children, Coverage also ends when they otherwise no longer meet the definition of Dependent children. For example, reach limiting age or are no longer a student. If survivors are not eligible for this extension or if Coverage ends under this rule, they could be eligible for Continuation of Coverage under COBRA shown later in this section.

LOSS OF HEALTH COVERAGE

Current Employees and their Dependents may have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage.

If the following conditions are met:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered; and

- The coverage under the other group health plan or health insurance policy was:

  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage is offered; or
  - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 30 calendar days after the date the other coverage ended.

- You and/or Your Dependents were covered under a Medicaid plan or state child health plan and Your or Your Dependents coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status.If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. You must request and apply for coverage within 30 calendar days of marriage, birth, adoption or Placement for Adoption.

NEWLY ELIGIBLE FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

Current Employees and their Dependents may be eligible for a Special Enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the date of the marriage (Note: Eligible individuals must submit their enrollment forms prior to the Effective Date of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or

- In the case of a Dependent's birth, on the date of such birth; or

- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or

- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or

- In the case of loss of coverage, on the date following loss of coverage.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

TERMINATION

For information about continuing coverage, refer to the COBRA section of this SPD.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or

- The date this Plan is canceled; or

- The date coverage for Your benefit class is canceled; or

- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or

- If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, the District Benefits Office can provide full details concerning your rights for Plan coverage during an approved leave of absence. You may retain your Plan individual coverage or family coverage while you are absent from work for an approved leave of absence. This continuation is not automatic. You must apply for continuation before your leave of absence starts. To remain eligible during a leave of absence without pay, you must remit your designated participation contribution, if any, to the District each month on a timely basis. The District Benefits Office can answer questions concerning their requirements and provide details on your participation payments for Plan continuation during a leave of absence. You could be required to pay the total premium equivalent for Plan participation. If you continue to be absent from work at the end of the approved leave of absence, Your Plan coverage will end. However, you could be eligible to elect continuation of the Plan coverage under COBRA. See COBRA Continuation of Coverage. If your Plan coverage ends while you are absent from work, it cannot be reinstated until you return to active employment. When you return to work, you must once more enroll in the Plan. The District Benefits Office can provide details on your effective dates of coverage following Plan enrollment as a returning Employee.

  Under the Family and Medical Leave Act (FMLA) of 1993, a Federal law, eligible Employees are entitled to receive up to 12 weeks of unpaid leave in a 12 consecutive month period for certain family and medical reasons. If you are on an FMLA leave, you may continue Plan Coverage by paying your monthly designated participation Contribution, if any, for individual or family Coverage. Plan continuation will be according to the FMLA, as amended. The District Benefits Office can provide details of your rights under the FMLA and your costs to continue coverage while on FMLA leave of absence

- The last day of the month in which You are no longer a member of a covered class, as determined by the employer except if You are temporarily absent from work due to active military duty. Refer to USERRA under the USERRA section; or

- The last day of the month in which Your employment ends; or

- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

- Ten (10) month employees resigning effective June 30th of any given year shall be provided with health insurance coverage during the succeeding July and August. Terminations, other than on that date, are treated the same as any other employee.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or

- The day of the month in which Your coverage ends except in the event that the Employee dies, Your enrolled Dependents should contact the District Benefits Office for complete details concerning eligibility and costs for Coverage under this rule. If an active Employee or Retiree dies, his or her survivor Dependents who are enrolled in his or her family coverage could be eligible for survivor enrollment. This extension of eligibility continues to apply to survivors of eligible Retirees or survivors of eligible Employees. To be covered, the survivors must request enrollment within 90 days after the death of the Employee or Retiree and pay designated participation costs. If enrollment is not made within 90 days, eligibility under this rule is not available. This coverage ends for the spouse and dependent Children when the survivor spouse remarries. For survivor Children, coverage also ends when they otherwise no longer meet the definition of Dependent Children. For example, reach limiting age or no longer a student. If survivors are not eligible for this extension or if coverage ends under this rule, they could be eligible for continuation of coverage under COBRA; or

- The day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides; or

- The day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section, unless the Child qualifies for Extended Dependent Coverage; or

  If Your Dependent Child qualifies for Extended Dependent Coverage as Disabled, the day of the month in which Your Dependent Child is no longer deemed Disabled under the terms of the Plan; or

- The date Dependent coverage is no longer offered under this Plan; or

- The day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or

- The day of the month in which the Dependent becomes covered as an Employee under this Plan; or

- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect; or
- it is attributable to non-payment of premiums or contributions.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, reduction of hours or lay-off and You qualify for eligibility under this Plan again at a later date, You must meet all requirements of a new Employee. Refer to the information on Family and Medical Leave Act or Uniformed Services Employment and Reemployment Act for possible exceptions, or contact Your Human Resources or Personnel office.

If Your coverage ends due to leave of absence and You qualify for eligibility under this Plan again at a later date, You are eligible for coverage on the date You return to work.

HIPAA PORTABILITY RIGHTS

CERTIFICATES OF CREDITABLE COVERAGE

New Employees and covered Dependents are encouraged to get a Certificate of Creditable Coverage from the individual's prior employer or insurance company. However, not all forms of coverage are required to provide certificates. If You or Your Dependents are having difficulty obtaining this, contact Your Human Resources or Personnel office for assistance.

Covered Persons will receive a Certificate of Creditable Coverage from this Plan when the person loses coverage under this Plan, when the person loses COBRA coverage, or upon a written request to this Plan if the individual is covered under this Plan or terminated from this Plan within the previous twenty four month period. The Certificate of Creditable Coverage is evidence of Your coverage under this Plan. Covered Persons may need evidence of coverage to reduce a Pre-Existing Condition exclusion period under another plan, to help get special enrollment in another plan, or to get certain types of individual health coverage.

Please submit written requests for a Certificate of Creditable Coverage from this Plan to the Claims Administrator identified in Appendix D.

Keep these Certificates in a safe place in case You or Your Dependents obtain coverage under another health plan that has a Pre-Existing Condition Exclusion Provision or become eligible for a Special Enrollment period under another plan. Proof of prior Creditable Coverage may reduce or eliminate the Pre-Existing Condition exclusion period, may be required to enroll in another plan under Special Enrollment, or may assist individuals in obtaining an individual insurance policy in the future.

COBRA CONTINUATION OF COVERAGE

Important. Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

The COBRA Administrator for this Plan is identified in Appendix D.

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries, the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

An Employee will become a Qualified Beneficiary if coverage under the Plan is lost because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled "The Right to Extend Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• Your spouse dies	up to 36 months
• Your spouse's hours of employment are reduced	up to 18 months
• Your spouse's employment ends for any reason other than his or her gross misconduct	up to 18 months
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• You become divorced or legally separated from Your spouse	up to 36 months

The Dependent Children of an Employee become Qualified Beneficiaries if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child stops being eligible for coverage under the plan as a Dependent	up to 36 months

COBRA continuation coverage for Retired Employees and their Dependents is described below:

• If You are a Retired Employee and Your coverage is reduced or terminated due to Your Medicare entitlement, and as a result Your Dependent's coverage is also terminated, Your spouse and Dependent Children will also become Qualified Beneficiaries.	up to 36 months
• If You are a Retired Employee and Your employer files bankruptcy under Title 11 of the United States Code this may be a Qualifying Event. If the bankruptcy results in Loss of Coverage under this Plan, then the Retired Employee is a Qualified Beneficiary. The Retired Employee's spouse, surviving spouse and Dependent Children will also be Qualified Beneficiaries if bankruptcy results in their Loss of Coverage under this Plan.	
➢ Retired Employee	Lifetime
➢ Dependents	36 months

Note: A spouse or Dependent Child newly acquired (newborn or adopted) during a period of 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, other than a newborn or newly adopted Child, acquired and enrolled after the original Qualifying Event, is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

To be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, either Your employer or the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information: (A form to notify the COBRA Administrator is available upon request.)

- The Qualified Beneficiary's name, their current address and complete phone number,
- The group number, name of the employer that the Employee was with,
- Description of the Qualifying Event (i.e., the life event experienced), and
- The date that the Qualifying Event occurred or will occur.

Send all notices or other information required to be provided by this Summary Plan Description in writing to the COBRA Administrator identified in Appendix D.

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when coverage terminates due to Qualifying Events that are the Employee's termination of employment or reduction in hours, death of the Employee, or the Employee becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days when these events occur.

EMPLOYEE OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of other Qualifying Events that are divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would lose coverage); or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, covered Employee or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that must be completed to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing to continue group health coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated back to the date coverage was lost, provided that the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will be effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however the Qualified Beneficiary will receive specific payment information including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or has discrepancies regarding the information on the check (i.e., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow him/her 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, then the occurrence will be treated as non-payment and the Qualified Beneficiary(s) will be termed from the Plan in accordance with the plan language above.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is required within 30 calendar days of:

- The date any Qualified Beneficiary marries. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.

- The date a Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.

- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- The date any Qualified Beneficiary becomes covered by another group health plan.

- Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents. 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only. 36 months from the Qualifying Event if coverage is lost due to one of the following events:

  - Employee's death.
  - Employee's divorce or legal separation.
  - Former Employee becomes enrolled in Medicare.
  - A Dependent Child no longer being a Dependent as defined in the Plan.

- For Retired Employees and Dependents of Retired Employees only. If bankruptcy of the employer is the Qualifying Event that causes Loss of Coverage, the Qualified Beneficiaries can continue COBRA continuation coverage for the following maximum period, subject to all COBRA regulations. The covered Retired Employee can continue COBRA coverage for the rest of his or her life. The covered spouse, surviving spouse or Dependent Child of the covered Retired Employee can continue coverage until the earlier of:

  - The date the Qualified Beneficiary dies; or
  - The date that is 36 months after the death of the covered Retired Employee.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled some time before the 60th day of COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualifying Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination within 60 days of the later of:

- The date of the SSA disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the Qualifying Event or the date that Plan coverage was lost; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events: (Dependents Only) If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B or both) or is divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event. A Dependent acquired during COBRA continuation (other than newborns and newly adopted Children) is not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will only lead to the extension when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan that the Qualified Beneficiary is under, but still maintains another group health plan for other similarly-situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same).

- The required contribution for the Qualified Beneficiary's coverage is not paid on time.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any Pre-Existing Condition(s) for the beneficiary.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer Disabled.

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)

Electing COBRA continuation coverage now may protect some of Your (or Your Dependent's) rights if You or Your Dependent need to obtain an **individual health insurance policy** soon. The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance carriers who offer coverage in the individual market must accept any eligible individuals who apply for coverage without imposing Pre-Existing Condition exclusions, under certain conditions. Some of those conditions pertain to COBRA continuation coverage. To take advantage of this HIPAA right, COBRA continuation coverage under this Plan must be elected and maintained (by paying the cost of coverage) for the duration of the COBRA continuation period. In the event that an individual health insurance policy is needed, You or Your Dependent must apply for coverage with an individual insurance carrier after COBRA continuation coverage is exhausted and before a 63-day break in coverage.

If You or Your Dependent will be obtaining **group health coverage** through a new employer, keep in mind that HIPAA requires employers to reduce Pre-Existing Condition exclusion periods if there is less than a 63-day break in health coverage (Creditable Coverage).

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before the Qualifying Event who is the Employee, the spouse of a covered Employee or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).
- The covered former Employee becomes enrolled in Medicare.
- A Dependent Child no longer being a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in loss of coverage as a result of active duty. Employees on leave for military service must be treated like they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following the military leave of absence cannot be subject to Pre-Existing Conditions and Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- 24 months beginning on the day that the Uniformed Service leave begins, or
- a period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

The word **"Network"** means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out which Network a provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- The Provider Network for this plan is identified in Appendix D. Claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

- If a provider belongs to other Networks identified in Appendix D, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits, but the providers have agreed to discount their fees. This means that the Covered Person may pay a little less for a particular claim than they would for an Out-of-Network claim.

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any.

For Transplant Services at a Designated Transplant Facility the Preferred Provider Organization is identified in the Appendix D.

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. When Non-Network charges are covered in accordance with Network benefits, the charges are still subject to the Usual and Customary charge limitations. The following exceptions may apply:

- Covered Services provided by a Physician, emergency room physicians, radiologist, anesthesiologist, or pathologist during an Inpatient stay will be payable at the In-Network level of benefits, subject to U & C, when provided at an In-Network Hospital

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

TRANSITIONAL CARE:

Certain eligible expenses that would have been considered at the PPO benefit level by the prior Claims Administrator but which are not considered at the PPO benefit level by the current Claims Administrator may be paid at the applicable PPO benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous PPO but who is not a member of the Plan's current PPO in the Employee or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the PPO medical plan benefit level may continue for 90 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the Covered Person is Inpatient in a Hospital on the effective date.
- Post acute Injury or Surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral Health – any previous treatment.

You or Your Dependent must call the claims administrator identified in Appendix D within 15 days prior to the effective date or within 30 days after the effective date to see if You or Your Dependent are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective surgical procedures will not be covered by transitional level benefits.

COVERED MEDICAL BENEFITS

Effective: 07-01-2013

This Plan provides coverage for the following covered benefits if services are authorized by a Physician and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions or other Plan provisions shown in this SPD. Services, drugs, supplies or equipment provided must be Medically Necessary as defined in the Glossary, Appendix A, of this Plan Document. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

1. **Abortions (Elective).**

2. **Alcohol Rehabilitation** (Refer to Substance Abuse section of this SPD).

3. **Allergy Treatment** including: injections, testing and serum.

4. **Ambulance Transportation:** When Medically Necessary, ground, sea and air transportation by a vehicle designed, equipped and used only to transport the sick and injured to the nearest medically appropriate Hospital.

Ambulance. Benefits are available for emergency land ambulance transportation when found Medically Necessary, according to Plan provisions. Air or sea ambulance is covered only when the patient's condition was so serious that the patient could not be transported safely by land ambulance or if the location, from which the patient required emergency transportation, was inaccessible by land ambulance. Benefits are only payable for emergency transportation by professional ambulance or volunteer ambulance. Benefits are not payable if the patient could have been safely transported by any other means of transportation. **No other type of transportation or travel is covered, whatever the reason.**

Coverage is provided for ambulance emergency services to the nearest Hospital that can treat the patient's condition. Emergency professional ambulance transportation to other locations may be considered based on patient's condition, reason for transfer, and Medical Necessity. For example, the Plan will not pay to have patient transferred to another Hospital when the primary reason is to be near his or her home. However, benefits would be allowed if the transfer was necessary because the first Hospital could not provide the necessary care and the patient required transfer to the nearest Hospital that could provide the needed care.

a. **Professional or** Hospital **Owned Ambulance** services are covered when ordered by a police officer or Physician for transportation to the nearest Hospital that can provide treatment for the patients Illness or Injury. Professional ambulances are Hospital owned, government owned or private owned services operating within the jurisdiction and in accordance with state and local regulations for professional ambulances. The Claims Administrator, according to Plan provisions, will decide other professional ambulance transportation Coverage.

b. **Volunteer Ambulance** transportation is covered only when needed for transportation to the nearest local Hospital. Volunteer ambulance transportation is a service rendered by an organized volunteer ambulance operating within the jurisdiction and in accordance with state and local government requirements. You must submit a bill or proof of donation to the Claims

Administrator.

5. **Anesthetics and their Administration.**

6. **Autism Services** limited to Physician office visits and diagnostic services.

7. **Breast Pumps** and related supplies.

8. **Breast Reductions** if Medically Necessary.

9. **Breastfeeding Support, Supplies and Counseling** 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.

10. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (See Glossary of Terms) as well as a result of an Illness or Injury.

11. **Cardiac Rehabilitation** programs are covered if referred by a Physician, for patients who have:

    - had a heart attack in the last 12 months; or
    - had coronary bypass surgery; or
    - a stable angina pectoris.

    Services covered include:

    - Phase I, while the Covered Person is an Inpatient.
    - Phase II, while the Covered Person is in a Physician supervised Outpatient monitored low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

12. **Cataract or Aphakia Surgery** as well as protective lenses following such procedure.

13. **Chiropractic Treatment** by a Qualified chiropractor. Services for diagnosis by physical examination and plain film radiography (x-ray), and when Medically Necessary for treatments for musculoskeletal conditions. Refer to Maintenance Therapy under the General Exclusions section of this SPD.

14. **Circumcision** and related expenses when care and treatment meet the definition of Medically Necessary. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

15. **Cleft Palate And Cleft Lip:** Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

16. **Contraceptives and Counseling:** All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling. This Plan provides benefits for Prescription contraceptives regardless of purpose. Prescription contraceptives that require a Physician to administer a hormone shot or insert a device (IUD) and the cost of the device will be processed under the Covered Medical Benefits in this SPD.

17. **Cornea Transplants** are payable at the percentage listed under All Other Covered Expenses on the Schedule of Benefits.

18. **Dental Services** include:

    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), excluding implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.

- Inpatient or Outpatient Hospital charges including professional services for x-ray, lab, and anesthesia while in the Hospital if Medically Necessary.
- Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

19. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs and nutritional counseling. Charges for dialysis for the treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. This also includes use of equipment or supplies, unless covered through the Prescription Benefits section. Charges are paid the same as any other Illness.

20. **Durable Medical Equipment:** subject to all of the following:

    - The equipment must meet the definition of Durable Medical Equipment as defined in the Glossary of Terms. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds and oxygen equipment.
    - The equipment must be prescribed by a Physician.
    - The equipment is subject to review under the Utilization Management Provision of this SPD, if applicable.
    - The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
    - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan.
    - If the equipment is purchased, benefits will be payable for subsequent repairs excluding batteries, or replacement only if required:
        - due to the growth or development of a Dependent Child;
        - when necessary because of a change in the Covered Person’s physical condition; or
        - because of deterioration caused from normal wear and tear.
    - The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

21. **Emergency Room Hospital and Physician Services** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

22. **Extended Care Facility Services:** for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. Covered Person must obtain prior authorization for services in advance. (Refer to the Utilization Management section of this SPD). The following benefits are covered:

    - Room and board.
    - Miscellaneous services, supplies and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

23. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
    - Treatment of corns, calluses and toenails, when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.

- Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.
- Covered charges do not include Palliative Foot Care.

24. **Genetic Counseling** if found to be Medically Necessary. Coverage will be limited to once per patient lifetime.

25. **Genetic Testing** if found to be Medically Necessary. Coverage will be limited to once per patient lifetime.

26. **Hearing Services** include exams, tests, services and supplies including Preventive Care, or to diagnose and treat a medical condition.

27. **Home Health Care Services:** (Refer to Home Health Care section of this SPD).

28. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and can include:

    - **Assessment** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
    - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
    - **Outpatient Care** provides or arranges for other services as related to the Terminal Illness which include: Services of a Physician; physical or occupational therapy; nutrition counseling provided by or under the supervision of a registered dietitian.
    - **Bereavement Counseling:** Benefits are payable for bereavement counseling services which are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and bundled with other hospice charges. Counseling services must be given by a licensed social worker, licensed pastoral counselor, psychologist or psychiatrist. The services must be furnished within twelve months of death.

    The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

29. **Hospital Services (Includes Inpatient Services, Surgical Centers And Birthing Centers).** The following benefits are covered:

    - Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate subject to Usual and Customary charges or the Negotiated Rate, whichever is applicable.
    - Intensive care unit room and board.
    - Miscellaneous and Ancillary Services.
    - Blood, blood plasma and plasma expanders, when not available without charge.

30. **Infant Formula** including enteral formulas which are a Covered Person's sole source of nutrition and for which a provider has issued a written order. The written order must state that the Medical Necessity is met for the enteral formula and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic disability, mental retardation or death.

31. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition, alleviates the symptoms, slows the harm, or maintains the current health status of the Covered Person. For Covered Persons, any age, the Plan covers the diagnosis and treatment of other correctable medical conditions covered by the

Plan even if that condition results in infertility. This includes prescription fertility drugs used in the treatment of that condition. Infertility treatment that is part of a treatment plan for reproduction or artificial conception procedures is not covered. Treatment for medical conditions only, not for the purpose of reproduction.

Infertility Services does not include Genetic Testing. (See General Exclusions for details).

32. **Kidney Dialysis.**

33. **Laboratory Or Pathology Tests And Interpretation Charges** for covered benefits.

34. **Maternity Benefits** for Covered Persons include:

    - Prenatal and postnatal care.
    - Hospital or Birthing Center room and board.
    - Obstetrical fees for routine prenatal care.
    - Vaginal delivery or Cesarean section.
    - Medically Necessary diagnostic testing.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Outpatient Birthing Centers.
    - Home births.
    - Midwifes.

35. **Mental Health Treatment** (Refer to Mental Health section of this SPD).

36. **Modifiers or Reducing Modifiers** if Medically Necessary, apply to services and procedures performed on the same day and may be applied to surgical, radiology and other diagnostic procedures. For providers participating with a primary or secondary network, claims will be paid according to the network contract. For providers who are not participating with a network, where no discount is applied, the industry guidelines are to allow the full Usual and Customary fee allowance for the primary procedure and a percentage (%) of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

37. **Nursery And Newborn Expenses Including Circumcision** are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

38. **Nutritional Supplements, Vitamins and Electrolytes** including enteral formulas which are a Covered Person's sole source of nutrition and for which a provider has issued a written order. The written order must state that the Medical Necessity is met for the enteral formula and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic disability, mental retardation or death.

39. **Occupational Therapy.** (See Therapy Services below)

40. **Oral Surgery** includes:

    - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
    - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
    - Reduction of fractures and dislocations of the jaw.
    - External incision and drainage of cellulitus.
    - Incision of accessory sinuses, salivary glands or ducts.
    - Excision of exostosis of jaws and hard palate.

41. **Orthotic Appliances, Devices and Casts,** including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after surgery.

42. **Oxygen And Its Administration.**

43. **Pharmacological Medical Case Management** (Medication management and lab charges).

44. **Physical Therapy.** (See Therapy Services below)

45. **Physician Services** for covered benefits.

46. **Pre-Admission Testing:** The testing must be necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

47. **Prescription Medications** which are administered or dispensed as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility or Skilled Nursing Facility) and that require a Physician's Prescription. This does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

48. **Preventive / Routine Care** as listed under the Schedule of Benefits.

    The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

    - Evidence-based items or services that have in affect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
    - With respect to infants, Children and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
    - Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
    - Well-woman preventive care visit(s) for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:

      - Screening for gestational diabetes;
      - Human papillomavirus (HPV) DNA testing;
      - Counseling for sexually transmitted infections;
      - Counseling and screening for human immune-deficiency virus; and
      - Screening and counseling for interpersonal and domestic violence.

      Please visit the following links for additional information:

      http://www.healthcare.gov/law/resources/regulations/prevention
      or
      http://www.hrsa.gov/womensguidelines/

49. **Private Duty Nursing Services** when care is required 24 hours a day, following first 48 hour exclusion per calendar year.

50. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) which replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

    - Due to the growth or development of a Dependent Child; or
    - When necessary because of a change in the Covered Person's physical condition; or
    - Because of deterioration caused from normal wear and tear.

    The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

51. **Radiation Therapy and Chemotherapy.**

52. **Radiology and Interpretation Charges.**

53. **Reconstructive Surgery** includes:

    - Following a mastectomy (Women's Health and Cancer Rights Act)
      The Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
    - Surgery to restore bodily function that has been impaired by a congenital Illness or anomaly, Accident, or from an infection or other disease of the involved part.

54. **Respiratory Therapy.** (See Therapy Services below)

55. **Second Surgical Opinion** must be given by a board-certified Specialist in the medical field relating to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

56. **Sleep Disorders** if Medically Necessary.

57. **Sleep Studies**.

58. **Speech Therapy.** (See Therapy Services below)

59. **Sterilizations (Voluntary).**

60. **Substance Abuse Services** (Refer to Substance Abuse section of this SPD).

61. **Surgery and Assistant Surgeon Services** (See Modifiers or Reducing Modifiers above).

62. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

    - **Occupational therapy** by a Qualified occupational therapist.
    - **Physical therapy** by a Qualified physical therapist.
    - **Respiratory therapy** by a Qualified respiratory therapist.
    - **Speech therapy** by a Qualified speech therapist.

63. **Transplant Services** (Refer to Transplant section of this SPD).

64. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

65. **Wigs, Toupees, Hairpieces** for hair loss due to cancer treatment.

66. **X-ray Services** for covered benefits.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients who are unable to leave their home, as determined by the Utilization Review Organization. Covered Persons must obtain prior authorization in advance before receiving services. Please refer to the Utilization Management section of this SPD for more details. Covered services can include:

- Home visits instead of visits to the provider's office that do not exceed the Usual and Customary charge to perform the same service in a provider's office.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a registered dietitian.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.
- If the attending Physician or the Home Health Care Agency considers it Medically Necessary, ambulance or ambulette transportation services between your home and the Hospital, if it is necessary for your care.

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A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a therapist or a registered dietician.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports or transportation.
- Expenses for the normal necessities of living such as food, clothing and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS

Effective: 07-01-2013

Refer To Utilization Management section of this SPD for prior authorization requirements

This coverage provides a choice for transplant care. Use of a Designated Transplant Facility provides incentives to You and Your covered Dependents. This coverage does not require that a Designated Transplant Facility be used in order to receive benefits, but it is preferred. A Designated Transplant Facility is a facility that must meet extensive criteria in the areas of patient outcomes to include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician's charges, organ and tissue procurement, tissue typing and Ancillary Services.

Designated Transplant Facility means a facility which has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Non-Designated Transplant Facility means a facility that does not have an agreement with the transplant provider network with whom the Plan has a contract. This may include a facility that is listed as a participating provider.

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation and the storage of human organ and tissue which is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic and syngeneic transplant of bone marrow, peripheral and cord blood stem cells.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated or Non-Designated Transplant Facility for an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge or the Plan’s Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated or Non-Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor related complications during the transplant period, as per the transplant contract, if the recipient is a Covered Person under this Plan.

The Plan will provide donor services at a Non-Designated Facility for initial acquisition/procurement only, up to the maximum listed on the Schedule of Benefits, if any. Complications, side effects or injuries are not covered unless the donor is a Covered Person on the Plan.

Benefits are payable for the following transplants:

- Kidney.
- Kidney/Pancreas.
- Pancreas, which meets the criteria as determined by the Utilization Management.
- Liver.
- Heart.
- Heart/Lung.
- Lung.
- Bone Marrow or Stem Cell transplant (allogeneic and autologous) for certain conditions.
- Small Bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by transplant facility, the Plan will allow them to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.

- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.

- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.

- Transplants considered Experimental, Investigational or Unproven.

- Solid organ transplant in patients with carcinoma unless the carcinoma is in complete remission for five (5) years or considered cured. Exceptions, which will require additional review for Medical Necessity, include: diagnoses of squamous cell and basal cell carcinoma of the skin and hepatocellular carcinoma.

- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.

- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION BENEFITS

Secondary Coverage. The Prescription Drug Expense Benefit does not apply if this Plan is secondary according to the COB order of benefit determination. See **Coordination of Benefits.** When this Plan is secondary, do not show your Plan identification card when drugs are purchased. If you or your Dependent obtain drugs through the Prescription Drug Expense Benefit when another plan is primary, you will be responsible for reimbursement of any Plan overpayments. See When another Plan is Primary described later in this section.

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. Medicare eligible individuals generally must pay an additional monthly premium for this coverage. In addition, electing Medicare Part D may affect Your ability to get prescription coverage under this Plan. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay an additional monthly penalty if they change their mind and sign up later. Medicare eligible individuals should have received a Notice informing them whether their current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage and explaining whether election of Medicare Part D will affect coverage available under this Plan. For a copy of this notice, please contact the Plan Administrator.

DEFINITIONS

Generic Drug means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Mail Service . If this Plan is primary, you may obtain maintenance drugs from the mail service pharmacy identified in the appendix. This service delivers the drug directly to your home.

Maintenance Drugs are medications that are taken for chronic conditions. Examples of chronic disorders are hypertension, heart disease, thyroid disease, and diabetes. In addition, acute care medications written for more than 21 days (one refill) may be obtained through the mail service. The mail service Pharmacy bills the Plan. You need only pay the applicable copayment, if any.

Non-Participating Pharmacy means any retail or mail order pharmacy that is not contracted by the Pharmacy Benefits Administrator and is excluded from the network of pharmacies. You and your Dependents may purchase drugs from any Pharmacy. However, if this Plan is considered the primary payer and you or your Dependents choose a Participating Pharmacy for maintenance drugs, you save costs for yourself and the District. Prescriptions obtained at a Non-Par Pharmacy may be submitted to the pharmacy benefits manager for reimbursement at the Participating Pharmacy allowable amount, less applicable copayment.

Participating Pharmacy means any retail or mail order pharmacy that is contracted by Pharmacy Benefits Administrator to be included in a network of pharmacies at a contracted amount.]

Pharmacy means a licensed establishment where Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

Pharmacy Benefits Administrator is an organization that manages payment for Prescriptions and services under the Plan.

Preferred Brand means a list of carefully selected medications that can assist in maintaining quality care for patients while helping to reduce the cost of Prescription Drug benefits under the Plan.

Prescription Drug means any drug that under Federal Drug Administration (FDA) or state law requires a written Prescription by a Physician or dentist or any other health care provider licensed to write Prescriptions by state law. Drugs that are available without a Prescription are considered non-legend drugs.

Drugs and medicines prescribed by a licensed Physician and dispensed by a licensed pharmacist are covered by the Plan, except as otherwise provided by the Plan. Outpatient Prescription Drugs will be covered subject to the applicable Co-pay amounts, and any limitations as stated in the Schedule of Benefits.

A Covered drug must be approved for use by the Food and Drug Administration for the purpose for which it is prescribed and dispensed by a licensed pharmacist or Physician.

Note: FDA approval of a drug does not guarantee inclusion as a covered item under the Prescription Drug program. Newly approved drugs may be subject to review by the Plan Sponsor before being covered or may be excluded altogether. In addition, the level of coverage for some Prescriptions may vary depending on the medication's therapeutic classification. As a result, some medications (including, but not limited to, newly approved Prescriptions) may be subject to quantity limits or may require prior authorization before being dispensed. For a specific up-to-date list of covered and/or excluded Prescription Drugs, contact the Pharmacy Benefits Manager identified in Appendix D.

The following are **excluded** through the Prescription Drug program (this list is **not** all-inclusive):

- Applicable exclusions listed under General Exclusions section of this SPD.
- Prescription products if a prior authorization was necessary but not received or denied.
- Prescription products that are available over-the-counter.
- Prescription products that do not have Food and Drug Administration (FDA) approval for the purpose for which prescribed.
- Weight loss drugs, anti-obesity/appetite suppressants.
- Therapeutic/diagnostic devices and appliances including needles, syringes, support garment and other non-medicinal substance or devices, whatever reason for use.
- Cosmetic medication including but not limited anti-wrinkle medications, dermatological medications, hair growth medications, any drugs FDA approved for cosmetic use only.
- Allergy extracts and blood or plasma.
- Vitamins, Minerals, food supplements or nutritional products that are obtainable without a prescription.
- Growth hormones.
- Drugs labeled "Caution-limited by federal law to investigational use", Experimental drugs or drugs prescribed for Experimental (non-FDA approved/unlabeled) indications
- Fluoride prep and dental rinses.
- Smoking deterrents whether or not by Physician prescription.
- Charges for the administration or injection of any medication.
- Medication which is to be taken by or administered to an individual, in whole or part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, Skilled Nursing Facility, Extended Care Facility, Convalescent Care Facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Drugs that are not considered Medically Necessary for treatment of an Illness or Injury even if obtainable only by prescription and even if prescribed by a Physician.
- Drugs and medicines purchased without written orders from the attending Physician are not payable, except for diabetic insulin and covered diabetic supplies
- All illegal drugs or supplies, even if prescribed by a duly licensed individual.

- Prescriptions that are in excess of the number of refills specified or dispensed more than one year after the order was written.
- Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation law, or any municipal, state or Federal program.

The Covered Person has a right to purchase an excluded product at his or her own cost if the product is excluded under this Plan.

For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in Appendix D.

1. Covered Prescription Drug Expenses. The maximum quantity of each covered drug purchased at one time will be limited to a 30 day supply when purchased at retail pharmacy or 90 days when purchased through the mail service pharmacy. Prescription refills will be paid for up to one (1) year from the date of the original prescription. Unless otherwise shown, all drugs must be ordered by the attending Physician and found Medically Necessary.

a. Medications that require a prescription by a licensed Physician and are Federal legend drugs unless otherwise excluded.

b. Compounded medications containing at least one prescription Federal legend ingredient in therapeutic amounts.

c. Diabetic insulin.

d. Tretinoin topical (e.g. Retin A) for Medical Necessity with a prescription. ***Requires preauthorization for Covered Persons, age 26 or older.***

e. Prescription drugs for treatment of infertility for persons ages between the ages of 21 and 44. Plan covers infertility drugs for persons of any age when used for treatment of other correctable medical conditions covered by the Plan ***(Requires preauthorization for Covered Persons under age 21 and ages 44 or older).*** **Note:** Infertility drugs used in connection with reproductive care or artificial conception treatment are not covered. See ***Treatment of Infertility*** in **Section III–Covered Services** under ***Miscellaneous Provisions*** for coverage details.

f. Prescription birth control pills for treatment of medical conditions. ***Requires preauthorization.*** Preauthorization is not required for birth control pills prescribed to prevent pregnancy.

g. Prenatal vitamins or other vitamins obtainable only with Physician's prescription.

h. Allergy emergency kits for emergency treatment of insect stings in allergic patients.

i. Drugs for treatment of impotency (Caverject, Muse, Edex and forms of testosterone used for treatment of impotence). Sildenalfil Citrate (Viagra or similar drug) when found medically necessary. ***Requires preauthorization.***

j. Other drugs that under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

2. **Preauthorization Requirements.** Some drugs require preauthorization before benefits become available. If the pharmacy advises that authorization is needed, phone the professional Utilization Management staff for the Pharmacy Benefit Program at the toll-free number on your ID Card for assistance. Drugs that require preauthorization include, but are not limited to, birth control drugs for treatment of medical condition, infertility or infertility drugs for persons under age 21 and age 44 or older when used for treatment of other correctable medical conditions, Impotency drugs or Sildenalfil Citrate (Viagra or similar drug) or Retin A or similar drug for persons, age 26 or older.

3. **Voluntary Generic Drug Substitution Program.** As part of a continuing effort to control costs and preserve the quality of the Plan, you are encouraged to use Generic Drugs whenever appropriate for your condition. A Generic Drug is a drug that is chemically equivalent to the original brand name drug. The only difference is that the patent on the brand name medication has expired allowing other manufacturers to sell the drug. As a result,

the generic manufacturer does not incur research costs and can charge significantly less for the drug. Since Generic Drugs cost less than brand name drugs, cost savings may result for you and the Plan when you substitute the lower priced drug. If you have any questions about Generic Drugs, ask for advice from your Physician or your pharmacist.

4. **When Another Plan is Primary.** If another health plan is considered primary coverage according to the Coordination of Benefits order of benefit the Prescription Benefits under this Plan will be coordinated with the primary plan benefits. When another Plan pays primary benefits, this Plan will coordinate its benefits as follows:

   For Spouse who has her/his own group health insurance, the allowable fees will be reduced by the primary plan benefit. The drug copayment will be applied to the balance of allowable fees. After the applicable copayment, This Plan pays the remaining balance of allowable fees up to it usual benefits.

   For Employee/Retiree and Other Dependents, the allowable fees will be reduced by the primary plan benefit. Then This Plan pays the balance of the allowable fees up to its usual plan benefit.

   To obtain Plan payment, claims must be submitted to the Pharmacy Benefits Manager identified in Appendix D with a copy of the other plan explanation of benefits or denial. **When this Plan is secondary, do not show your Plan identification card, do not obtain benefits through this Plan. If you obtain benefits from this Plan when this Plan is secondary, you will be required to reimburse any resulting benefit overpayments.**

5. **Copayments.** You or your Dependents will be required to pay the applicable Copayment for covered generic or brand name drugs at the time of purchase. The brand name Copayment is more than the Generic Drug Copayment. Please refer to **Summary of Benefits** under ***Prescription Drug Expense Benefits*** for Copayment details.

6. **Plan Identification Card.** You must use your Plan identification card at any Participating Pharmacy. The Pharmacy may display the participation logo or you may ask the Pharmacy if it is a Participating Pharmacy.

7. **Obtaining Benefits.** To obtain your covered drug or supply at Participating Pharmacy costs, you need only present your Plan identification card and the written prescription to the pharmacist, then pay the applicable Copayment amount. The Pharmacy will bill the Pharmacy Benefits Manager directly and will receive direct payment from them. If you do not present your Plan identification card at the time of purchase, you must file your own claim and benefits will be allowed as if the drug was purchased at a Nonparticipating Pharmacy.

Questions or concerns about the drug program can be answered by The Pharmacy Benefits Manager. You may contact them by calling the toll-free number on your ID Card, or send a written inquiry.

8. How to Use the Mail Service Pharmacy Program

When your Doctor writes a prescription for a "maintenance drug" (one taken regularly or on a long-term basis) ask him or her to indicate the number of refills allowed. Contact the Pharmacy Benefit Manager identified in Appendix D for information about the Mail Service Pharmacy.

a. Complete the on line enrollment with the mail service pharmacy, or other applicable enrollment requirement(s).
b. Your medication will be delivered to you by first-class mail or UPS. You should allow 10-14 days from the time you place your order until delivery of your medication. *However, to ensure that you do not leave yourself without an adequate supply of medication, you will be best protected if you order when you have a minimum of a three-week supply of your*

current medication.

9. **Vacation Supply.** If you or your Dependents are going on vacation and need to replenish your supply before a normal refill date, you may phone the **Pharmacy Benefit Manager Identified in Appendix D.**

10. **Prescription Drug Expense Exclusions.** In addition to exclusions and limitations shown above, see also **Plan Exclusions** shown later in this SPD.

For a specific up-to-date list of covered and/or excluded Prescription Drugs, contact the Pharmacy Benefits Manage identified in the Appendix D.

MENTAL HEALTH BENEFITS

The Plan will pay the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Participation amounts, maximum or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Usual and Customary amount, maximum fee schedule or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services are payable subject to all of the following:

- The Hospital or facility must be accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency or dual diagnosis facility for the treatment of Mental Health Disorders. If outside of the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

- The Covered Person must have the ability to accept treatment.

- The Covered Person must be ill in more than one area of daily living to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the Covered Person's condition would deteriorate.

- The Covered Person's Mental Health Disorder must be treatable in an Inpatient facility.

- The Covered Person's Mental Health Disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the Covered Person's Mental Health Disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region.

- The attending Physician must be a psychiatrist. If the admitting Physician is not a psychiatrist, a psychiatrist must be attending to the Covered Person within 24 hours of admittance. Such psychiatrist must be United States board eligible or board certified. If outside of the United States, Inpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial and prevocational modalities. Such programs must be a less restrictive alternative to Inpatient treatment. Each two days of Partial Hospitalization will reduce the number of Inpatient days available to the Covered Person by one day.

Outpatient Services are payable subject to all of the following:

- Must be in person at a medical facility appropriately licensed to deliver the services for which charges are submitted; and

- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and

- Must be provided by one of the following, as defined in your Medical Schedule of Benefits, Appendix B:

  - A United States board eligible or board certified psychiatrist licensed in the state where the treatment is provided.
  - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).
  - A state licensed psychologist.
  - If outside of the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.
  - Licensed Professional Counselor
  - Licensed Nurse Practitioner
  - Certified Addiction Counselor
  - A state licensed or certified or clinical social worker.
  - Masters in social work.
  - Licensed Clinical Social Worker (LCSW).
  - Master of Science Social Worker (MSSW).
  - Psychologists.

ADDITIONAL PROVISIONS AND BENEFITS

- A medication evaluation by a psychiatrist may be required before a Physician can prescribe medication for psychiatric conditions. Periodic evaluations may be requested by the Plan.

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Inpatient charges for the period of time when full, active Medically Necessary treatment for the Covered Person's condition is not being provided.

- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.

- Services provided for conflict between the Covered Person and society which is solely related to criminal activity.

- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases - Clinical Modification manual (most recent revision) (ICD-CM) in the following categories:

  - Personality disorders; or
  - Behavior and impulse control disorders; or
  - "V" codes (including marriage counseling).

- Services for biofeedback.
- Residential treatment services.

SUBSTANCE ABUSE, CHEMICAL DEPENDENCY AND ALCOHOL REHABILITATION BENEFITS

The Plan will pay the following Covered Expenses for a Covered Person subject to any Deductibles, Co-pays if applicable, Participation amounts, maximum or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, Usual and Customary amount or the Negotiated Rate as applicable.

COVERED BENEFITS

Inpatient Services are payable subject to all of the following:

- The Hospital or facility must be accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency or dual diagnosis facility for the treatment of substance abuse and chemical dependency. If outside of the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

- The Covered Person must have the ability to accept treatment.

- The Covered Person must be ill to such an extent that they require the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the Covered Person's condition would deteriorate.

- The Covered Person's condition must be treatable in an Inpatient facility.

- The Covered Person's condition must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the Covered Person's condition must meet diagnostic criteria established and commonly recognized by the psychiatric community in that region.

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such programs must be a less restrictive alternative to Inpatient treatment. Each two days of Partial Hospitalization will reduce the number of Inpatient days available to the Covered Person by one day.

Outpatient Services are payable subject to all of the following:

- Must be in person at a medical facility appropriately licensed to deliver the services for which charges are submitted; and

- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and

- Must be provided by one of the following:

  - A United States board eligible or board certified psychiatrist licensed in the state where the treatment is provided.
  - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).

- A state licensed psychologist.
- If outside of the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located, or a therapist with a Ph.D., or master's degree that denotes a specialty in psychiatry. The attending Physician, psychiatrist, or a counselor must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of substance abuse and chemical dependency disorders.
- A state licensed or certified or clinical social worker.
- Licensed professional counselor.
- Nurse Practitioner.
- Masters in social work.
- Certified addiction counselor.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for change. Such records must include: the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

SUBSTANCE ABUSE EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

The Plan will not pay for:

- Treatment or care considered inappropriate or substandard as determined by the Plan.

- Inpatient charges for the period of time when full, active Medically Necessary treatment for the Covered Person's condition is not being provided.

- Services provided in a community-based residential facility or group home.

UTILIZATION MANAGEMENT
And Other Medical Management Services

Effective: 07-01-2013

Utilization Management is the process of evaluating whether services, supplies or treatment are Medically Necessary and appropriate to help ensure cost-effective care. Utilization Management can eliminate unnecessary services, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons should call the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

Special Note: The Covered Person will not be penalized for failure to obtain Prior Authorization if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 48 hours of the first business day after receiving care or Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

Pre-admission and Home Health Care Review. The Pre-admission review is a preliminary evaluation by the professional Utilization Management staff to decide whether an Inpatient setting is Medically Necessary according to Plan provisions. If the Medical Necessity of the Inpatient setting is established based on available information, the admission will be pre-certified. If the Medical Necessity is not established based on available information, the Inpatient admission will not be pre-certified. You are also required to call *before home health care starts* for a preliminary evaluation. The professional Utilization Management staff will mail their written notice of their review decision to you, the ordering Doctor or Physician and the facility usually within 48 hours (two business days).

The pre-admission or home health care certification does not guarantee benefits to you or your Provider and will not result in payment of benefits that would not otherwise be payable. It is a preliminary review of the Inpatient setting or Home Health Care Plan that is based entirely on the limited information provided to the professional Utilization Management staff at the time of the pre-admission review. If medical documentation at the time services are rendered is other than the information provided during this initial review, and it is decided according to Plan provisions and limitations that the Hospitalization or home care was not Medically Necessary or otherwise excluded under the Plan, benefits may be denied.

Mandatory Enrollee Telephone Requirement. Others may initiate the required phone call, such as Family Members, Physicians, or facility personnel. However, it is your responsibility to confirm that the call was made. This review applies to any Hospital or other Covered facility in the USA, including Hawaii and Alaska. The purpose of the Enrollee or Covered Person telephone call is to initiate the pre-admission review and to advise the patient whether Coverage is available. If this Plan is primary, you must call the professional Utilization Management staff before a scheduled admission or after an emergency admission to any Inpatient facility or before Home Health Care Agency services are rendered. **Phone toll-free telephone number on your ID Card.** You are required to call as follows:

1. At least 24 hours (or one business day) before an admission or when the Physician decides that you or one of your Dependents requires admission to a Hospital, Skilled Nursing Facility, Psychiatric Facility, or any other Inpatient facility; or

2. Within 48 hours after an emergency or urgent admission; or
3. Within 24 hours following continued maternity Inpatient stays after 48 hours after normal delivery or 96 hours after cesarean section. For all other maternity admissions, follow instructions shown in "a." or "b." above; or
4. Within 24 hours following continued Inpatient stays after 96 hours for newborns.
5. Before Home Health Care starts.

Noncompliance Benefit Reduction/Inpatient Admissions

Informing the Hospital, facility or the Physician of the pre-admission review requirement does not eliminate this benefit reduction if the phone call is not made. If you fail to make the pre-admission phone call, and it is decided at the time of claim submission, that the Inpatient admission was not Medically Necessary, benefits could be denied.

If you fail to comply with the phone call requirements of this review, you will be subject to a ***$250.00 reduction*** of available benefits for Hospital or other Inpatient facility Covered Services or Supplies.

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

This Plan complies with the Newborns and Mothers Health Protection Act. The Prior Authorization requirement is not required for Hospital or Birthing Center stays of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for stays beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is **identified in Appendix D.**

DEFINITIONS

The following terms are used for the purpose of the Utilization Management section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Prior Authorization is the process of determining benefit coverage prior to service being rendered to an individual member. A determination is made based on Medical Necessity criteria for services, tests or procedures that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the effectiveness and appropriateness of health care services and treatment plans. Such assessment can be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Management Organization **before** receiving services for the following:

- Scheduled Inpatient stay in a Hospital. At least 24 hours (or one business day) before an admission or when the Physician decides that you or one of your Dependents requires admission to a Hospital, Skilled Nursing Facility, Psychiatric Facility, or any other Inpatient facility.
- Organ and tissue transplants.
- Home Health Care.
- Inpatient stay in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.
- Breast reduction surgery.
- Eye lid surgery.
- Panniculectomy surgery (or similar surgery).
- Varicose vein surgery.
- MRI or MRA and PET scans.
- Inpatient stay in a Hospital for mental health and substance abuse confinements.
- Outpatient visits for mental health and substance abuse.

Note that if a Covered Person receives Prior Authorization for one facility, but then the person is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non- Prior Authorization penalty is the amount that must be paid by a Covered Person who does not call for Prior Authorization prior to receiving certain services. A penalty of $250 will be applied per admission if a Covered Person receives services but did not obtain the required Prior Authorization for:

- Scheduled Inpatient stay in a Hospital. At least 24 hours (or one business day) before an admission or when the Physician decides that you or one of your Dependents requires admission to a Hospital, Skilled Nursing Facility, Psychiatric Facility, or any other Inpatient facility.
- Organ and tissue transplants.
- Home Health Care.
- Inpatient stay in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.
- Breast reduction surgery.
- Eye lid surgery.
- Panniculectomy surgery (or similar surgery).
- Varicose vein surgery.
- MRI or MRA and PET scans.
- Inpatient stay in a Hospital for mental health and substance abuse confinements.
- Outpatient visits for mental health and substance abuse.

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

Even though a Covered Person provides Prior Authorization to the Utilization Review Organization, that does not guarantee that this Plan will pay for the medical care. The Covered Person still needs to be eligible for coverage on the date services are provided. Coverage is also subject to all of the provisions described in this SPD.

Medical Director Oversight. A Case Management medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine medical appropriateness using evidence-based clinical criteria.

Case Management Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger cases to case management for review. These triggers include ICD-9 diagnosis codes, CPT codes, length-of-stay criteria and claims dollar thresholds, as well as specific criteria requested by the Plan Administrator. Information is easily passed from Utilization Management to case management through our fully-integrated care management software system.

All Prior Authorization requests are used to identify the member's needs. Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted by Plan Administrator request as long as the request is received within 30 days of the original determination. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures.

Other Medical Management Services

Case Management Services are designed to identify catastrophic and complex Illnesses, transplants and trauma cases. Case management specialists identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified from the Prior Authorization review process, national criteria and system flags based on ICD-9 diagnosis, CPT procedure code and potential high dollar claim criteria. Case management specialists work directly with the patient, family members, treating Physician and facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious Illness helps avoid major complications in the future. The Covered Person can request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual automobile policies. See order of benefit determination rules (below) and General Exclusions - no-fault state for details.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law. See below. This does not include Medicaid.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges 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.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule to use:

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier. See General Exclusions – no-fault state in this SPD for more details.

- The plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan.

- The plan that covers a person as a Dependent is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent (see continuation coverage below). (Also see the section on Medicare, below, for exceptions).

- When an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.

- If one or more plans cover the same person as a Dependent Child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
    - If both parents have the same birthday, the plan that covered either of the parents longer is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or Dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or Dependent of a retired or laid off employee), the plan that covers the person as an active employee (or Dependent of an active employee) will be primary.

- Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

When this Plan is not Primary and a Covered Person is receiving Part A Medicare but has chosen not to elect Part B, this Plan will reduce its payments on Part B services as though Part B Medicare was actually in effect.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:
    - ➢ You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
    - ➢ You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and is also covered under a retiree plan through Your spouse's former employer. In this case, this Plan will be primary for You and Your covered spouse, Medicare pays second, and the retiree plan would pay last.
    - ➢ For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
    - ➢ You are no longer actively employed by an employer; and
    - ➢ You or Your spouse has Medicare coverage due to age, plus You or Your spouse also have COBRA continuation coverage through the Plan; or
    - ➢ You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first, however an exception is that COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or
    - ➢ You or Your covered spouse have retiree coverage plus Medicare coverage; or
    - ➢ Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).

- Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

Note: If a Covered Person is eligible for Medicare as the primary plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether the Covered Person is enrolled in Medicare.

TRICARE

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT, AND OFFSET

Effective: 07-01-2013

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the Plan has paid Covered Expenses on Your behalf for an Illness or Injury for which a third party is considered responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the Covered Expenses that the Plan has paid that are related to the Illness or Injury for which a third party is considered responsible.

The right to reimbursement means that if a third party causes or is alleged to have caused an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any covered benefit you received for that Illness or Injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused Covered Expenses to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or Injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to deny future covered benefits, take legal action against You, and/or set off from any future covered benefits the value of covered benefits we have paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If you or your Dependent fail to tell this Plan that you or your Dependent has a claim against a third party; if you or your Dependent fails to assign your claim against the third party to the Plan when required to do so (and to cooperate with this Plan's subsequent recovery efforts); if you or your Dependent fails to require any attorney subsequently retained to sign the Plan's lien forms; if you and/or your Dependent and/or authorized representative or attorney fail to fully reimburse this Plan out of any payment obtained from the third party or fail to fully reimburse the Plan, then you are personally liable to this Plan for the reimbursement owed this Plan as the result of the third party payment or settlement. This Plan may then request reimbursement from you and offset the amount you owe from any future benefit claims for any Covered Family Member or if necessary and/or take legal action against you.

The Plan reserves the right to deny benefits for any charges that are or could be considered subject to the Plan's right of reimbursement in the case of failure by you and/or your Eligible Dependent or legal representative to comply with the above conditions. The conditions shown above will not apply to benefits paid under Medicare supplementary coverage nor to any payments made under any insurance policy, plan or certificate issued to you or your Dependents.

If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You or Your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common-Fund Doctrine" or "Attorney's Fund Doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You will hold those funds in trust, either in a separate bank account in Your name or in Your attorney's trust account. You agree that You will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

- The Plan's rights to recovery will not be reduced due to Your own negligence.

- Upon our request, You will assign to us all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these subrogation provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party and filing suit in Your name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries.

- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If a third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

GENERAL EXCLUSIONS

Effective: 01-01-2019

Exclusions, including complications from excluded items are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan. In addition to the exclusions listed below, additional exclusions, specific to some services may be found throughout this document,

The Plan does not pay for Expenses Incurred for the following, unless otherwise stated below. The Plan does not apply exclusions based upon the source of the Injury to treatment listed in the Covered Medical Benefits section when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence. When in doubt, contact the Third Party Administrator identified in Appendix D for Prior Authorization of Services.

1. **Acts Of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

2. **Acupuncture Treatment.**

3. **Alternative / Complimentary Treatment** includes: Treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.

4. **Appointments Missed:** An appointment the Covered Person did not attend.

5. **Aquatic Therapy.**

6. **Assistance With Activities of Daily Living. Unless covered elsewhere in this Document.**

7. **Assistant Surgeon Services.** Covered when such assistance is found Medically Necessary to do a covered surgical procedure. (A hospital rule or requirement does not, in itself, establish Medical Necessity). The assistance must be in a Hospital or other facility where there is no qualified staff available to assist the surgeon. The Allowable Fees for the assistant surgeon will be based on 20% of the Plan Allowable Fees for the surgical procedure(s).

8. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.

9. **Biofeedback Services**.

10. **Blood:** Blood donor expenses. Services or Supplies for autologous or directed blood donations and/or storage when done as precautionary measure in case the need for blood arises. Exception: Autologous or directed donation services or supplies preceding Surgery as specifically included in the Plan.

11. **Blood Pressure Cuffs / Monitors.**

12. **Cardiac Rehabilitation** beyond Phase II, all of which are considered to be maintenance, including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

13. **Chelation Therapy,** except in the treatment of conditions considered Medically Necessary, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.

14. **Claims** received later than March 31, of the year following the year expenses were incurred.

15. **Cosmetic Treatment**, **Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

16. **Counseling Services** in connection with financial or marriage counseling. Treatment must be directed at a diagnosed Mental Illness. Benefits are not payable for care that is primarily directed at raising the level of consciousness, social enhancement, training or retraining, support groups, counseling limited to everyday problems of living, marriage counseling, parent-child counseling, family counseling or sex therapy. Under no circumstances are benefits provided for therapy that includes the satisfaction of requirements for professional training.

17. **Court-Ordered:** Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.

18. **Custodial Care** as defined in the Glossary of Terms of this SPD.

19. **Custom-Molded Shoe Inserts,** including the exam for required Prescription and fitting.

20. **Dental Services:**

    - The care and treatment of teeth, gums or alveolar process or for dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges including professional charges for x-ray, lab and anesthesia, or for charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw which was fractured or dislocated in an Accident.
    - Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
    - Dental implants including preparation for implants.

21. **Developmental Delays:** Occupational, physical, and speech therapy services related to Developmental Delays, mental retardation or behavioral therapy are not Medically Necessary and are not considered by the Plan to be medical treatment. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

22. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.

23. **Education:** Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

24. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.

25. **Examinations:** Examinations for employment, insurance, licensing or litigation purposes.

26. **Excess Charges:** Charges or the portion thereof which are in excess of the Usual and Customary charge, the Negotiated Rate or fee schedule.

27. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatment.

28. **Extended Care:** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.

29. **Family Planning:** Consultation for family planning.

30. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building.

31. **Foot Care/Shoes/Orthotics/Supports (Podiatry):** Routine foot care, services or supplies related to routine foot care such as cutting or removal of corns, calluses, nails, routine hygienic care, or preventive Maintenance Care (ordinarily within the realm of self-care). Orthopedic shoes, foot orthotics or other supportive foot devices and for treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia, bunions or subluxation of the foot despite underlying pathology. Exceptions: Routine foot care ordered by an attending medical Doctor while treating a person with an insulin dependent diabetic condition, removal of nail roots and open cutting corrective procedures.

31. **Genetic Counseling** unless found to be Medically Necessary. Coverage will be limited to once per patient lifetime.

32. **Genetic Testing** unless found to be Medically Necessary. Coverage will be limited to once per patient lifetime.

33. **Hearing Services:**

    - Purchase or fitting of hearing aids unless covered elsewhere in this SPD.
    - Implantable hearing devices unless covered elsewhere in this SPD.

34. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steambaths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.

35. **Infertility Treatment:**

    - Surgical reversal of a sterilized state which was a result of a previous surgery.
    - Direct attempts to cause pregnancy by any means including, but not limited to hormone therapy or drugs.
    - Artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT).
    - Embryo transfer.
    - Freezing or storage of embryo, eggs, or semen.
    - Genetic testing.

    This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition, slow the harm to, alleviate the symptoms, or maintain the current health status of the Covered Person.

36. **Lamaze Classes** or other child birth classes.

37. **Learning Disability:** Non-medical treatment, including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

38. **Liposuction** regardless of purpose.

39. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

40. **Mammoplasty or Breast Augmentation** unless covered elsewhere in this SPD.

41. **Massage Therapy.**

42. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

43. **Military:** A military related Illness or Injury to a Covered Person on active military duty, unless payment is legally required.

48. **Nocturnal Enuresis Alarm** (Bed wetting).

49. **No-Fault State:** Services or supplies to the extent they are covered under a mandatory motor vehicle liability law that requires benefits be provided for personal Injury without regard to fault, This applies whether or not a claim is made for payment under that coverage. Benefits under this Plan will automatically be denied if the automobile insurance denies its benefits as not Medically Necessary or for late filing. However, expenses not paid under the no-fault insurance due to its deductible and maximum benefits limitations, will be paid covered to the extent allowable fees would otherwise have been payable under this Plan.

50. **Inpatient Non-Acute Care/Custodial/Maintenance/Long Term Care.** Services or Supplies related to any admissions or part of an Inpatient stay that is primarily for physical checkups, diagnostic testing Custodial Care, Maintenance Care or long term care, residential, sanitarium type, rest cures, or for environmental change or care that cannot reasonably be expected to lessen the patients disability enabling him or her to leave an institution. Exception: Hospice care services specifically included in the Plan.

51. **Non-Custom-Molded Shoe Inserts.**

52. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.

53. **Not Medically Necessary:** Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy, above.

54. **Nursery and Newborn Expenses** for grandchildren of a covered Employee or spouse.

55. **Nutrition Counseling** unless covered elsewhere in this SPD.

56. **Nutritional Supplements, Vitamins and Electrolytes** except as listed under the Covered Medical Benefits.

57. **Orthognathic, Prognathic and Maxillofacial Surgery.** Unless found to be Medically Necessary.

58. **Over-The-Counter Medication, Products, Supplies or Devices** unless covered elsewhere in this SPD.

59. **Panniculectomy / Abdominoplasty** unless determined by the Plan to be Medically Necessary.

60. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

61. **Pharmacy Consultations.** Charges for or relating to consultative information provided by a pharmacist regarding a prescription order, including but not limited to information relating to dosage instruction, drug interactions, side effects, and the like.

62. **Prescription Medication**, which is administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility and that require a Physician's Prescription.

63. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

64. **Return to Work / School:** Telephone or Internet consultations or completion of claim forms or forms necessary for the return to work or school.

65. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.

66. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

67. **Self-Administered Services** or procedures that can be done by the Covered Person without the presence of medical supervision.

68. **Services at no Charge or Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

69. **Services** that should legally be provided by a school.

70. **Services Provided by a Close Relative.** See Glossary of Terms of this SPD for definition of Close Relative.

71. **Sex Therapy.**

72. **Sexual Function:** Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence.

73. **Sex Transformation:** Treatment, drugs, medicines, services and supplies for, or leading to, sex transformation surgery.

74. **Standby Surgeon Charges.**

75. **Subrogation.** Charges for Illness or Injuries suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Subrogation section. See the Subrogation section for more information.

76. **Surrogate Motherhood or Gestational Carrier Services** including any services or supplies provided in connection with a surrogate pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate mother.

77. **Taxes:** Sales taxes, shipping and handling unless covered elsewhere in this SPD.

78. **Telemedicine -** Telephone or Internet Consultations made by a Covered Person's treating Physician to another Physician.

79. **Temporomandibular Joint Disorder (TMJ) Services:**

- Diagnostic services.
- Surgical treatment.
- Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension).

This does not cover orthodontic services.

80. **Third Party Claim Settlement/Action:** Services for supplies for which payment is received or are reimbursable because of claim settlement or legal action (third party claim or action), other than from an insurance carrier under an individual policy issued to you or your Dependent. Exception: Conditional payments shown in Right of Subrogation, Reimbursement and Offset. Failure to comply with the conditions of the Plan's right to subrogation could result in denial of benefits.

81. **Tobacco Addiction:** Diagnoses, services, treatment or supplies related to addiction to or dependency on nicotine.

82. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

83. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.

84. **Vision Care** unless covered elsewhere in this SPD.

85. **Vitamins, Minerals and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.

86. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

87. **Weekend Admissions** to Hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the Plan, unless the admission is deemed an Emergency, or for care related to pregnancy that is expected to result in childbirth.

88. **Weight Control:** Treatment, services or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling.

89. **Wigs, Toupees, Hairpieces, Hair Implants or Transplants or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this SPD.

90. **Work-Related/Occupational Conditions:** Services or supplies received because of an occupational Injury or an occupational Illness that entitles the Covered Person to benefits under a worker's compensation, occupational disease law, or similar legislation. Payment will not be made even if You or Your Dependent does not claim the entitled benefits.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided. Although not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. Covered Persons or providers may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore cannot be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as <u>required</u> by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to get approval from the Plan ***before*** obtaining the medical care such as in the case of prior authorization of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan just to find out if a claim will be covered, that is not a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization (See Pre-Determination above). Giving prior authorization does not guarantee that the Plan will ultimately pay the claim.

  Note that this Plan does not require prior authorization for urgent or Emergency care claims, however Covered Persons may be required to notify the Plan following stabilization. Please refer to the Utilization Management section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation when a sudden and serious condition such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of his or her bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. Minor Dependents must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit a written letter to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant their Personal Representative access to their Protected Health Information. This letter must be signed by the Covered Person to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, then the Covered Person will need to send the claim to the Plan within the timelines discussed below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

Covered Persons who receive services in a country other than the United States are responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person/patient ID number, name, sex, date of birth, Social Security number, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Diagnosis
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, auto accident, or other accident (if applicable)
- Assignment of benefits (if applicable)

PROOF OF LOSS

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than March 31, of the year following the year expenses were incurred. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the proof of loss period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly follow the Plan's procedures for requesting prior authorization, the Plan will notify the person to explain proper procedures within five calendar days following receipt of a Pre-Service claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When the claims administrator receives a claim for services that have been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If it is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If it is a covered benefit, the claims administrator will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to an established fee schedule, a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

Fee Schedule: Generally, providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, Co-pay or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's allowable charge used in the calculation of the payable benefit.

Negotiated Rate: On occasion, the claims administrator will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care Facility treatment or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying.
Where a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Usual And Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 85th percentile, see surgery and assistant surgeon under the covered benefits for exceptions related to multiple procedures. As it relates to charges made by a network provider, the term Usual and Customary means the Negotiated Rate as contractually agreed to by the provider and network (see above). A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

The claims administrator will process claims within the following timelines, although the Covered Person may voluntarily extend these timelines:

- Pre-Service Claim: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan can have an extra 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan can have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.

- Emergency and/or Urgent Care Claim: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the medical necessity, but not later than 72 hours after the receipt of the claim by the Plan.

A claim is considered to be filed when the claim for benefits has been submitted to the claims administrator for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Usual and Customary fee limits, fee schedule or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

APPEAL PROCEDURES

A. First Step Appeals. The Appeal procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by third-party administrator. For example, it applies to contractual benefit denials or issues or concerns you have regarding third-party administrative policies or access to Providers.

B. Filing an Appeal. You can contact the third-party administrator by phone at the number on your ID card, in person, or in writing to file an Appeal. You may submit an oral Appeal in connection with a denial of a Referral or a covered benefit determination. Third-party administrator may require that you sign a written acknowledgement of your oral Appeal, prepared by the third-party administrator. You or your designee has up to 180 calendar days from when you received the decision you are asking the third-party administrator to review to file the Appeal.

The third-party administrator will keep all requests and discussions confidential and will take no discriminatory action because of your issue. The third-party administrator will have a process for both standard and expedited Appeals, depending on the nature of your inquiry.

C. Appeal Determination. Qualified personnel will review your Appeal, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. The third-party administrator will decide the Appeal and notify you within the following timeframes:

Expedited/Urgent Appeals:	By phone, within 72 hours of receipt of your Appeal. Written notice will be provided within 72 hours of receipt of your Appeal.
Pre-Service Appeals: (A request for a service or treatment that has not yet been provided.)	In writing, within 30 calendar days of receipt of your Appeal.
Post-Service Appeals: (A claim for a service or treatment that has already been provided.)	In writing, within 60 calendar days of receipt of your Appeal.
All Other Appeals: (That are not in relation to a claim or request for a service or treatment.)	Call third-party administrator.

D. Second Step Appeals.

1. **For Carmel Teachers Association (CTA) Participants:** If you are not satisfied with the resolution of your Appeal, you may seek review by the CTA Health Benefits Subcommittee
    i. Submit your appeal, in writing, to the CTA Health Benefits Subcommittee. The subcommittee will review the claim determination and claim documents and the committee will provide you with a written response within 30 days of the receipt of your appeal. This written response will cite the reasons for their decision and the specific Plan provision, limitation, or exclusion upon which they based their decision. If the Appeal Subcommittee's resolution does not satisfy you, you may seek a review with the CTA Health Benefits Committee.

    ii. If you disagree with the resolution by the CTA Health Benefits Appeals Subcommittee, you may request a review by the CTA Health Benefits Committee. To do this, you should do the following:

        1. Your request for a review must be in writing to the Assistant Superintendent for Business within 60 days from receipt of the Appeal Subcommittee's response to your appeal.

2. The CTA Health Benefits Committee will convene and review your appeal. They will provide you with a written determination on your appeal. The committee will respond within 30 days of the receipt of your appeal.

2. For all others: you may request a review by the Carmel Health Benefits Committee. To do this, you should do the following:

i. Submit your appeal, in writing to the Assistant Superintendent for Business within 30 days from the receipt of your Appeal determination. You may use the same information that you submitted at the Appeal determination of this process.
ii. Your appeal will be presented to the Carmel Health Benefits Committee. The committee will review the claim determination and claim documents and the committee will provide you with a written response within 30 days of the receipt of your appeal. This written response will cite the reasons for their decision and the specific Plan provision, limitation or exclusion upon which they based their decision.

UTILIZATION REVIEW

A. **Utilization Review.** The third-party administrator reviews health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions, please contact the third-party administrator listed on your ID card.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. The third-party administrator does not compensate or provide financial incentives to their employees or reviewers for determining that services are not Medically Necessary. The third-party administrator has developed guidelines and protocols to assist in this process. For substance use disorder treatment, the third-party administrator will use evidence-based and peer reviewed clinical review tools designated by OASAS that are appropriate to the age of the patient. Specific guidelines and protocols are available for your review upon request.

B. **Preauthorization Reviews.**

1. **Non-Urgent Preauthorization Reviews.** If the third-party administrator has all the information necessary to make a determination regarding a Preauthorization review, the third-party administrator will make a determination and provide notice to you (or your designee) and your Provider, in writing, within fifteen (15) calendar days of receipt of the request. If the third-party administrator need additional information, the third-party administrator will request it within fifteen (15) calendar days. You or your Provider will then have 45 calendar days to submit the information. If the third-party administrator receives the requested information within 45 days, they will make a determination and provide notice to you (or your designee) and your Provider, in writing, within fifteen (15) calendar days of the third-party administrator's receipt of the additional information. If all necessary information is not received within 45 days, they will make a determination within 15 calendar days of the end of the 45 day period allowed to submit the additional information.

2. **Urgent Preauthorization Reviews.** With respect to urgent preauthorization requests, if the third-party administrator have all information necessary to make a determination, they will make a determination and provide notice to you (or your designee) and your Provider, in writing, within 72 hours of receipt of the request.

If the third-party administrator's need additional information, they will request it within 24 hours. You or your Provider will then have 48 hours to submit the information. The third-party administrator will make a determination and provide notice to you (or your designee) and your Provider, in writing, within 48 hours of the earlier of their receipt of the additional information or the end of the 48-hour period allowed to submit additional information.

3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if you (or your designee) certify, in a format prescribed by the Superintendent of Financial Services, that you will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, The third-party administrator will make a determination and provide notice to you (or your designee) and your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of our telephonic and written notification will also be provided to the court.

4. **Crisis Stabilization Centers.** Coverage for services provided at participating crisis stabilization centers licensed under New York Mental Hygiene Law section 36.01 is not subject to Preauthorization. The third-party administrator may review the treatment provided at crisis stabilization centers retrospectively to determine whether it is Medically Necessary and they will use clinical review tools designated by OASAS or approved by OMH. If any treatment at a participating crisis stabilization center is denied as not Medically Necessary, you are only responsible for the In- Network Cost-Sharing that would otherwise apply to your treatment.

C. **Concurrent Reviews**

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your Provider, in writing, within fifteen (15) calendar days of receipt of all necessary information.

   If the third-party administrator needs additional information, they will request it within fifteen (15) calendar days of the receipt of the request. You or your Provider will then have 45 calendar days to submit the additional information. They will make a determination and provide notice to you (or your designee) and your Provider, in writing, within fifteen (15) calendar days of their receipt of the additional information or, if they do not receive the information, within 15 calendar days of the end of the 45- day period allowed to provide the additional information.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, the third-party administrator will make a determination and provide notice to you (or your designee) and your Provider within 24 hours of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and the third-party administrator has all the information necessary to make a determination, they will make a determination and provide written notice to you (or your designee) and your Provider within 72 hours of receipt of the request. If need additional information, they will request it within 24 hours. You or your Provider will then have 48 hours to submit the information. The third-party administrator will make a determination and provide written notice to you (or your designee) and your Provider within the earlier of one (1) business day or 48 hours of their receipt of the information or, if they do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to the third-party administrator at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, they will make a determination within 24 hours of receipt of the request and will provide coverage for the inpatient substance use disorder treatment while the determination is pending.

D. **Retrospective Reviews.** If the third-party administrator has all information necessary to make a determination regarding a retrospective claim, they will make a determination and notify you and your Provider within 30 calendar days of the receipt of the request. If the third-party administrator need additional information, they will request it within 30 calendar days. You or your Provider will then have 45 calendar days to provide the information. The third-party administrator will make a determination and provide notice to you and your Provider in writing within 15 calendar days of the earlier of their receipt of all or part of the requested information or the end of the 45-day period.

Once they have all the information to make a decision, their failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. **Retrospective Review of Preauthorized Services.** The third-party administrator may only reverse a preauthorized treatment, service or procedure on retrospective review when:

1. The relevant medical information presented to them upon retrospective review is materially different from the information presented during the Preauthorization review;
2. The relevant medical information presented to them upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to them;
3. The third-party administrator was not aware of the existence of such information at the time of the Preauthorization review; and
4. Had they been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the preauthorization review.

F. **Reconsideration.** If the third-party administrator did not attempt to consult with your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and your Provider and in writing.

G. **Utilization Review Internal Appeals.** You, your designee, and, in retrospective review cases, your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal. The third-party administrator will acknowledge your request for an internal appeal which will include the name, address, and phone number of the person handling your appeal and, if necessary, inform you of any additional information needed before a decision can be made. The appeal will be decided by a clinical peer reviewer from the third-party administrator who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to appeal the denial of a preauthorization request for an out-of-network health service when the third-party administrator determines that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, you or your designee must submit:

    i. A written statement from your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat your condition, that the requested out-of-network health service is

materially different from the alternate health service available from a Participating Provider that the third-party administrator approved to treat your condition; and

ii. Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to you than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Authorization Denial.** You also have the right to Appeal the denial of a request for an authorization to a Non-Participating Provider when the third-party administrator determines that they have a Participating Provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network authorization denial, you or your designee must submit a written statement from your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat your condition:

   i. That the Participating Provider recommended by the third-party administrator does not have the appropriate training and experience to meet your particular health care needs for the health care service; and
   ii. Recommending a Non-Participating Provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service.

H. **First Level Appeal.**

1. **Preauthorization Appeal.** If your appeal relates to a preauthorization request, the third-party administrator will decide the appeal within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate your Provider within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

2. **Retrospective Appeal.** If your appeal relates to a retrospective claim, the third-party administrator will decide the Appeal within 60 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee) and where appropriate your Provider within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.

3. **Expedited Appeal.** An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order or any other urgent matter will be handled on an expedited basis. An expedited appeal is not available for retrospective reviews. For an expedited appeal, your Provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one (1) business day of receipt of the request for an appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited appeal will be determined within the earlier of 72 hours of receipt of the appeal or two (2) business days of receipt of the information necessary to conduct the appeal.

   If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external review.

   Substance Use Appeal. If the third-party administrator denies a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and you or your Provider file an expedited internal appeal of their adverse determination, they will decide the appeal within 24 hours of receipt of the appeal request. If you or your Provider file the expedited internal appeal and an expedited

external review within 24 hours of receipt of their adverse determination, the third-party administrator will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal appeal and external review is pending.

I. **Second Level Appeal.** If you disagree with the first level appeal determination, you or your designee can file a second level appeal. You or your designee can also file an external review. **The four (4) month timeframe for filing an external review begins on receipt of the final adverse determination on the first level of appeal. By choosing to file a second level appeal, the time may expire for you to file for external review.**

A second level appeal must be filed within 60 days of receipt of the final adverse determination on the first level appeal. The third-party administrator will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your appeal and inform you, if necessary, of any additional information needed before a decision can be made.

1. **Preauthorization Appeal.** If your appeal relates to a Preauthorization request, the third-party administrator will decide the appeal within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

2. **Retrospective Appeal.** If your appeal relates to a retrospective claim, the third-party administrator will decide the appeal within 60 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.

EXTERNAL REVIEW

A. If the outcome of the mandatory first level appeal is adverse to you, and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

B. For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through their internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

C. All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to the third-party administrator.

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If your health benefit Plan is sponsored by your Employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

The District reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor, upon reasonable notice.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

These actions will result in denial of the Covered Person's claim or termination from the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Covered Persons must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your Plan identification card is lost, report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should contact the Claims Administrator found in the Appendix D. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid; and
- The Employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

An Employee can choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken, and no new pre-existing requirements will be imposed. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn Child to less than 48 hours following a vaginal deliver**y**, or less than 96 hours following a Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Physician (e.g., Your Physician, nurse, or midwife, or a physician assistant) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers 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 plan or issuer may not, under federal law, require that a Physician or other health care provider obtain prior 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 Your out-of-pocket costs, You may be required to obtain prior authorization. For information on prior authorization, contact Your plan administrator.

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- The Americans with Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Health Insurance Portability provisions of the Health Insurance Portability and Accountability Act (HIPAA).
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- The Genetic Information Nondiscrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan shall Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor shall Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan.

This Plan agrees that it will only Disclose a Covered Person's PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will only Use and Disclose a Covered Person's PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Covered Persons have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Benefits Coordinator

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a BA is a person to whom the CE discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Sponsor means Your employer.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, in the alternative, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy will be excluded from any benefit consideration.

The Plan will assume that the Covered Person received the written amendment or termination letter from the Plan Administrator five days after the letter is mailed.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between any Covered Person and the employer.