CITY OF LEWISBURG

HEALTH BENEFIT PLAN

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

(March, 2013)

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ADOPTION

City of Lewisburg has caused this City of Lewisburg Health Benefit Plan ***(Plan)*** to take effect as of the first day of March, 2013, at Lewisburg, West Virginia. This is a revision of the Plan previously adopted March 1, 2008. I have read the document herein and certify the document reflects the terms and conditions of the employee welfare benefit plan as established by City of Lewisburg.

BY:_____ DATE:_____

SUMMARY PLAN DESCRIPTION

Name of Plan:

City of Lewisburg Health Benefit Plan

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

City of Lewisburg
119 West Washington Street
Lewisburg, West Virginia 24901
Phone: 304-645-2080

Employer Identification Number:

55-6000198

Plan Number:

501

Type of Plan:

Welfare Benefit Plan: medical and prescription drug benefits

Type of Administration:

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

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

City of Lewisburg
119 West Washington Street
Lewisburg, West Virginia 24901
Phone: 304-645-2080

Eligibility Requirements:

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

Eligibility
Enrollment
Effective Date of Coverage

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

Schedule of Benefits
Effective Date of Coverage, Pre-existing Conditions
Termination of Coverage
Plan Exclusions

Source of Plan Contributions:

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

Funding Method:

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

Ending Date of Plan Year:

February 28

Procedures for Filing Claims:

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Claim Filing Procedures.*

The designated ***claims processor*** is:

The Employee Benefit Service Center
4430 Kanawha Turnpike
South Charleston, West Virginia 25309
Phone: (800) 310-6645
www.ebscenter.com

Grandfathered Plan:

This group health ***Plan*** believes this ***Plan*** is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Being a grandfathered plan means that the ***Plan*** does not include certain consumer protections of the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the ***Plan administrator*** at (304) 645-2080. The ***Plan*** participant may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa.

Statement of ERISA Rights:

As a participant in the City of Lewisburg Health Benefit Plan the participant is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About The Plan and Benefits

Examine, without charge, at the ***plan administrator's*** office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the ***plan administrator***, copies of documents governing the operation of the ***plan,*** including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form

5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the ***plan's*** annual financial report. The ***plan administrator*** is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for the ***employee***, spouse or ***dependents*** if there is a loss of coverage under the ***plan*** as a result of a qualifying event. The ***employee*** or his or her ***dependents*** may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing the COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the group health plan, if the ***covered person*** has creditable coverage from another plan. The ***covered person*** should be provided a certificate of creditable coverage, free of charge, from their group health plan or health insurance issuer when they lose coverage under the plan, when they become entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if they request it before losing coverage, or if they request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, the ***covered person*** may be subject to a ***preexisting condition*** exclusion for twelve (12) months (eighteen (18) months for ***late enrollees***) after the ***covered person's*** enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for ***plan*** participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate this ***plan,*** called "fiduciaries" of the ***plan,*** have a duty to do so prudently and in the interest of ***plan*** participants and beneficiaries. No one, including the ***employer***, a union, or any other person, may fire the ***employee*** or otherwise discriminate against the ***employee*** in any way to prevent the ***employee*** from obtaining a welfare benefit or exercising his or her rights under ERISA.

Enforce The Rights

If a claim for a welfare benefit is denied or ignored, in whole or in part, the ***covered person*** has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a ***covered person*** can take to enforce the above rights. For instance, if the ***covered person*** requests a copy of ***plan*** documents or the latest annual report from the ***plan*** and does not receive them within thirty (30) days, the ***covered person*** may file suit in a Federal court. In such a case, the court may require the ***plan administrator*** to provide the materials and pay the ***covered person*** up to one hundred ten dollars ($110) a day until the ***covered person*** receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the ***covered person*** has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or Federal court. In addition, if the ***covered person*** disagrees with the ***plan's*** decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the ***covered person*** may file suit in Federal court. If it should happen that ***plan*** fiduciaries misuse the ***plan's*** money, or if the ***covered person*** is discriminated against for asserting his or her rights, they may seek assistance from the U.S. Department of Labor, or they may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the ***covered person*** is successful, the court may order the person they have sued to pay these costs and fees. If the ***covered person*** loses, the court may order them to pay these costs and fees, for example, if it finds the claim is frivolous.

Assistance with Questions

If the ***covered person*** has any questions about this ***plan***, they should contact the ***plan administrator***. If the ***covered person*** has any questions about this statement or about their rights under ERISA, or if they need assistance in obtaining documents from the ***plan administrator***, they should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The ***covered person*** may also obtain certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Conformity With Applicable Laws

This ***Plan*** shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this ***Plan,*** including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the ***Plan administrator*** to pay claims which are otherwise limited or excluded under this ***Plan,*** such payments will be considered as being in accordance with the terms of this ***Plan*** document. It is intended that the ***Plan*** will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable laws.

HIPAA PRIVACY STATEMENT

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The ***Plan*** will use protected health information (PHI) to the extent of an in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the ***Plan*** will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

"Payment" includes activities undertaken by the ***Plan*** to obtain premiums or determine or fulfill its responsibility for coverage and provision of ***Plan*** benefits that relate to a ***covered person*** to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and coinsurance amounts (for example, cost of a benefit or ***Plan*** maximums as determined for a ***covered person's*** claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing ***employee*** contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement; and
- Reimbursement to the ***Plan.***

"Health Care Operations" include, but are not limited to, the following activities:

- Quality assessment;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and ***Plan*** performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and creating, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the ***Plan,*** including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the ***Plan***, including, but not limited to:
  - (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or

(b) customer service, including the provision of data analysis for policyholders, plan sponsors or other customers;

- Resolution of internal grievances.

THE PLAN WILL USE AND DISCLOSE PHI TO THE PLAN ADMINISTRATOR AND AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE COVERED PERSON

With an authorization, the ***Plan*** will disclose PHI to other health benefit plans, health insurance issuers or HMOs for purposes related to the administration of these plans.

The ***Plan*** will disclose PHI to the ***Plan administrator*** only upon receipt of a certification from the ***Plan administrator*** that the ***Plan*** documents have been amended to incorporate the following provisions.

WITH RESPECT TO PHI, THE PLAN ADMINISTRATOR AGREES TO CERTAIN CONDITIONS

The ***Plan administrator*** agrees to:

- Not use or further disclose PHI other than as permitted or required by the ***Plan*** document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the ***Plan administrator*** provides PHI received from the ***Plan*** agree to the same restrictions and conditions that apply to the ***Plan administrator*** with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by a ***covered person;***
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the ***Plan administrator*** unless authorized by the ***covered person;***
- Report to the ***Plan*** any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to a ***covered person*** in accordance with HIPAA's access requirements***;***
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from the ***Plan*** available to the Health and Human Services Secretary for the purpose of determining the ***Plan's*** compliance with HIPAA;
- If feasible, return or destroy all PHI received from the ***Plan*** that the ***Plan administrator*** still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- Reasonably and appropriately safeguard electronic PHI created, received, maintained or transmitted to or by the ***Plan administrator*** on behalf of the ***Plan***. Specifically, such safeguarding entails an obligation to:
    - Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that the ***Plan administrator*** creates, receives, maintains or transmits on behalf of the ***Plan****;*
    - Ensure that the adequate separation as required by 45 C.F.R. 164-504(f)(20(iii) is supported by reasonable and appropriate security measures;

- Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the ***Plan*** any security incident of which it becomes aware**.**

SEPARATION BETWEEN PLAN ADMINISTRATOR AND PLAN

The following ***employees*** or classes of ***employees*** under the control of the ***Plan administrator*** may be given access to PHI by the ***Plan*** or a business associate servicing the ***Plan:***

1. Company Privacy Officer

2. Company Officer-In-Charge of the Benefit Plan

3. Company Benefit Plan Coordinator

4. Medical Reviewer(s)/Case Management on Behalf of the Plan

5. Legal Counsel on Behalf of the Plan

6. Third Party Administrator(s) on Behalf of the Plan

7. Actuaries on Behalf of the Plan

8. Plan Auditor(s)

The ***employees*** who are included in this description will have access to PHI only to perform the administration functions that the ***Plan administrator*** provides to the ***Plan***. ***Employees*** who violate this provision will be subject to sanction. The ***Plan administrator*** will promptly report any violation of this provision to the ***Plan*** and will cooperate with the ***Plan*** to remedy or mitigate the effect of such violation.

SCHEDULE OF BENEFITS

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

MEDICAL BENEFITS:

Maximum Benefit Per Covered Person Per Calendar Year For:

Medical	$2,000,000
Extended Care Facility	120 days
TMJ/Jaw Joint	$1,000

Calendar Year Deductible:

	Preferred Provider	***Nonpreferred Provider***
Individual Deductible (Per Person)	$250	$500
Family Deductible (Aggregate)	$500	$1,000

Out-of-Pocket Expense Limit Per Calendar Year: (excludes deductible)

	Preferred Provider	***Nonpreferred Provider***
Individual (Per Person)	$1,000	$2,000
Family (Aggregate)	$2,000	$4,000

Refer to *Medical Expense Benefit, Calendar Year Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.

Coinsurance:

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***incurred covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit,* for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance.***

All services subject to deductible unless otherwise indicated.

Benefit Description	***Preferred Provider***	***Nonpreferred Provider***
Inpatient Hospital	80%	60%
Outpatient Surgery	80%	60%
Emergency Room Services ***Emergency*** situations only	80%	60%
Accident Expense Benefit (Deductible waived) Limitation: $300 ***maximum benefit*** per accident	100%	100%

Benefit Description	***Preferred Provider***	***Nonpreferred Provider***
Physician's Services		
Home, Inpatient and Office Visit	80%	60%
Surgery - Physician's Office	80%	60%
Surgery - Other	80%	60%
Pathology	80%	60%
Anesthesiology	80%	60%
Radiology	80%	60%
Diagnostic X-rays & Lab		
Inpatient or Outpatient	80%	60%
Second Surgical Opinion		
First $200 per opinion (Deductible waived)	100%	100%
Thereafter	80%	60%
Extended Care Facility	80%	60%
Limitation: 120 days ***maximum benefit*** per calendar year		
Home Health Care (Deductible waived)	100%	100%
Hospice Care	80%	60%
Durable Medical Equipment	80%	60%
Well Child Care		
First $200 per calendar year (Deductible waived)	100%	100%
Thereafter	80%	60%
Well Adult Care		
First $200 per calendar year (Deductible Waived)	100%	100%
Thereafter	80%	60%
Mental & Nervous Disorders		
Inpatient Services	80%	60%
Outpatient Services	80%	60%
Chemical Dependency		
Inpatient Services	80%	60%
Outpatient Services	80%	60%
Therapy Services	80%	60%
Chiropractic Care	80%	60%
Ambulance Service	80%	80%
Jaw Joint/TMJ	80%	60%
Limitation: $1,000 ***maximum benefit*** per calendar year		
Allergy Testing, Injections and Serum	80%	80%

Benefit Description	***Preferred Provider***	***Nonpreferred Provider***
Preadmission Testing (Deductible waived)	100%	100%
Dental and Eye Care Services (Deductible waived) Limitation: $300 ***maximum benefit*** per calendar year	100%	100%
All Other Covered Expenses	80%	60%

PRESCRIPTION DRUG PROGRAM:

Participating Pharmacy

Prescription Drug Card ***Copay***	100% after ***copay;*** Generic: $5 ***copay*** Formulary Brand Name: $15 ***copay*** Non-Formulary Brand Name: $25 ***copay*** Limitation: 31 day supply

90-Day Supply

Mail Order Prescriptions Copay	100% after ***copay;*** Generic: $10 per prescription Formulary Brand Name: $30 per prescription Non-Formulary Brand Name: $50 per prescription Limitation: 90 day supply

*You will be able to obtain a 90-day supply of maintenance medication from a participating pharmacy. Your physician must write your prescription for a 90-day supply. The *first* fill of a *new* maintenance medication will be for a 30-day supply only.

UTILIZATION REVIEW

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

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

The ***Plan*** requires precertification of certain services, supplies or treatment, as specified below. Under this ***Plan's*** claim filing procedures, the precertification call is considered to be filing a ***pre-service claim*** for benefits. Please see *Claim Filing Procedures* for details regarding a ***covered person's*** rights regarding ***pre-service claim*** determinations and appeals.

PRECERTIFICATION

Hospital/Outpatient Surgery/Biopsies/MRIs, PET Scans and CT Scans

All ***hospital*** admissions, ***outpatient*** surgeries (except those performed in a ***physician's*** office), biopsies, MRIs, PET Scans and CT Scans are to be certified in advance of the proposed ***confinement,*** surgery or test (precertification) by the ***Utilization Review Organization,*** except for ***emergencies***. The ***covered person*** or their representative should call the ***Utilization Review Organization*** at least fourteen (14) days prior to admission, surgery or test.

Covered persons should contact the Utilization Review Organization by calling:

1-800-854-8206

Emergency hospital admissions are to be reported to the ***Utilization Review Organization*** within forty-eight (48) hours of the first business day following admission.

*Group health plans generally may not, under federal law, restrict benefits for any **hospital** length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law require that a provider obtain authorization from the **Plan** for prescribing a length of stay not in excess of the above periods.*

However, ***hospital*** maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above must be precertified.

Benefits payable for any service requiring precertification (except biopsies) surgeries shall be reduced by fifty percent (50%) if precertification is not obtained.

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

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

Precertification from the ***Utilization Review Organization*** does not constitute ***Plan*** liability for any ***pre-existing condition*** charges during the ***pre-existing condition*** waiting period.

PRECERTIFICATION APPEAL PROCESS

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

CASE MANAGEMENT/ALTERNATE TREATMENT

In cases where the ***covered person's*** condition is expected to be or is of a serious nature, the ***employer*** may arrange for review and/or case management services from a professional qualified to perform such services. The ***employer*** shall have the right to alter or waive the normal provisions of this ***Plan*** when it is reasonable to expect a cost effective result without a sacrifice to the quality of care. The use of case management or alternate treatment is a voluntary program to the ***covered person;*** however, the ***Plan*** will generally provide a greater benefit to the ***covered person*** by participating in the program.

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

PREFERRED PROVIDER OR NONPREFERRED PROVIDER

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

PREFERRED PROVIDERS

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

NONPREFERRED PROVIDERS

A ***nonpreferred provider*** does not have an agreement in effect with the ***Preferred Provider Organization.*** {Use the next two sentences when the plan's coinsurance is based on C&R} This ***Plan*** will allow only the ***customary and reasonable amount*** as a ***covered expense.*** The ***Plan*** will pay its percentage of the ***customary and reasonable amount*** for the ***nonpreferred provider*** services, supplies and treatment. The ***covered person*** is responsible for the remaining balance. This results in greater out-of-pocket expenses to the ***covered person.***

REFERRALS

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

EXCEPTIONS

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

1. ***Nonpreferred*** anesthesiologist if the operating ***facility*** is a ***preferred provider.***

2. Emergency room ***physician*** services, radiologist or pathologist services for interpretation of x-rays and laboratory tests rendered by a ***nonpreferred provider*** when the ***facility*** rendering such services is a ***preferred provider.***

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

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

5. For ***emergency*** treatment rendered while traveling out-of-area.

6. When a covered ***dependent*** resides outside the service area of the ***Preferred Provider Organization,*** for example a ***full-time student, covered expenses*** shall be payable at the ***preferred provider*** level of benefits.

7. ***Covered persons*** who do not have access to ***preferred providers*** within thirty-five (35) miles of their place of residence,

8. ***Emergency*** treatment rendered at a ***nonpreferred facility.*** If the ***covered person*** is admitted to the ***hospital*** after such ***emergency*** treatment, ***covered expenses*** shall be payable at the ***preferred provider*** level.

MEDICAL EXPENSE BENEFIT

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

DEDUCTIBLES

Individual Deductible

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

Family Deductible

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

Common Accident

If two or more covered members of a family are ***injured*** in the same accident and, as a result of that accident, incur ***covered expenses,*** only one individual deductible amount will be deducted from the total ***covered expenses*** of all covered family members related to the accident for the remainder of the calendar year.

Deductible Carry-Over

Amounts ***incurred*** during October, November and December and applied toward the deductible of any ***covered person,*** will also be applied to the deductible of that ***covered person*** in the next calendar year.

COINSURANCE

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

CALENDAR YEAR OUT-OF-POCKET EXPENSE LIMIT

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

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

Out-of-Pocket Expense Limit Exclusions

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

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

2. Deductible.

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

MAXIMUM BENEFIT

The *Schedule of Benefits* contains separate ***maximum benefit*** limitations for specified conditions.

HOSPITAL AND MEDICAL BILL AUDIT PROGRAM

The ***Plan*** will provide a cash incentive for discovering, correcting and reporting any overcharges on a ***hospital*** or other medical bill to the ***Plan administrator.*** Eligible bills are those that are for ten dollars ($10) or more. Overcharges are considered charges for ***covered expenses*** that were never received or rendered. Items which are considered ineligible expenses (such as for telephone or telephone charges) are not considered overcharges. In order to receive the cash incentive, the ***covered person*** must:

1. Send the ***claims processor*** a copy of the original itemized billing with the overcharged items circled and the original correct itemized billing within ninety (90) days of the date of service.

2. If the provider agrees to reduce the billing by the overcharged amount, the ***Plan*** will pay the ***covered person*** fifty percent (50%) of the savings up to a maximum of payment of five hundred dollars ($500) per invoice.

If the ***covered person*** is covered under this ***Plan*** and another plan, this provision is only available if this ***Plan*** is the primary payor.

HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient hospital admissions and ***outpatient*** surgeries (except those performed in a ***physician's*** office) are subject to precertification. Failure to obtain precertification will result in a reduction of benefits, refer to *Utilization Review.*

Covered expenses shall include:

1. ***Room and board*** for treatment in a ***hospital,*** including ***intensive care units,*** cardiac care units and similar necessary accommodations. ***Covered expenses*** for ***room and board*** shall be limited to the ***hospital's***

semiprivate rate. ***Covered expenses*** for ***intensive care*** or cardiac care units shall be the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable***.*** In a ***hospital*** that has only private rooms, ***covered expenses*** for ***room and board*** shall be limited to eighty percent (80%) of the ***hospital's*** average private room rate.

A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the ***covered person.***

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

3. Services, supplies and treatments described above furnished by an ***ambulatory surgical facility.***

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

FACILITY PROVIDERS

Services of ***facility*** providers if such services would have been covered if performed in a ***hospital*** or ***ambulatory surgical facility.***

EMERGENCY SERVICES/EMERGENCY ROOM

No benefits are payable for emergency room treatment that is not for an ***emergency*** situation, as defined herein, or for treatment of an accidental ***injury.***

AMBULANCE SERVICES

Ambulance services must be by a licensed air or ground ambulance.

Covered expenses shall include:

1. Ambulance services for air or ground transportation for the ***covered person*** from the place of ***injury*** or serious medical incident to the nearest ***hospital*** where treatment can be given, unless the ***Plan administrator*** determines that a longer trip is ***medically necessary***.

2. Ambulance service is covered in a non-emergency situation only to transport the ***covered person*** to or from a ***hospital*** or between ***hospitals*** for required treatment when such treatment is certified by the attending

physician as ***medically necessary.*** Such transportation is covered only from the initial ***hospital*** to the nearest ***hospital*** qualified to render the special treatment.

ACCIDENT EXPENSE BENEFIT

Initial treatment and follow-up care within ninety (90) days of an ***injury*** will be payable, as specified on the *Schedule of Benefits*. Benefits are payable only to the extent that no benefits are payable for the charges under any other benefits of this ***Plan*** (other than the *Medical Expense Benefit).*

Covered expenses shall include charges for the following:

1. ***Physician*** services;

2. ***Hospital*** care and treatment;

3. Diagnostic x-rays and lab tests;

4. Local professional ambulance service;

5. Surgical dressings, splints and casts and other devices used in the reduction of fractures and dislocations;

6. Nursing service;

7. Anesthesia;

8. Covered prescription drugs;

9. Use of a ***physician's*** office or clinic operating room.

PHYSICIAN SERVICES

Covered expenses shall include:

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

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

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

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

3. Surgical assistance provided by a ***physician*** if it is determined that the condition of the ***covered person*** or the type of surgical procedure requires such assistance. ***Covered expenses*** for the services of an assistant surgeon shall be limited to twenty percent (20%) of the surgeon's allowable amount.

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

5. Consultations requested by the attending ***physician*** during a ***hospital confinement.*** Consultations do not include staff consultations which are required by a ***hospital's*** rules and regulations.

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

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

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

SECOND SURGICAL OPINION

The second surgical opinion benefit is not subject to any deductible.

1. Benefits for a second surgical opinion will be payable according to the *Schedule of Benefits* if an ***elective surgical procedure*** (non-emergency surgery) is recommended by the ***physician,*** and if a second surgical opinion is required by the ***Utilization Review Organization***.

2. The ***physician*** rendering the second opinion regarding the ***medical necessity*** of such surgery must be a board certified specialist in the treatment of the ***covered person's illness*** or ***injury*** and must not be affiliated in any way with the ***physician*** who will be performing the actual surgery.

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

4. The second surgical opinion benefit includes ***physician*** services and any diagnostic services as may be required.

5. If an ***elective surgical procedure*** is performed prior to obtaining a required second surgical opinion, the ***Plan's*** benefit payment for the surgeon’s charges will be reduced by fifty percent (50%) ***covered expenses*** related to the ***elective surgical procedure.***

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging and x-ray. MRIs, PET Scans and CT Scans are subject to precertification. Failure to obtain precertification shall result in a reduction in benefits.

TRANSPLANT

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

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

2. When the donor is covered under this ***Plan,*** the ***Plan*** will pay the donor's ***covered expenses*** related to the transplant, provided the recipient is also covered under this ***Plan. Covered expenses incurred*** by each person will be considered separately for each person.

3. Expenses ***incurred*** by the donor who is not ordinarily covered under this ***Plan*** according to *Eligibility* requirements will be ***covered expenses*** to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this ***Plan.*** The donor's expense shall be applied to the recipient's ***maximum benefit.*** In no event will benefits be payable in excess of the ***maximum benefit*** still available to the recipient.

4. Surgical, storage and transportation costs in the United States and Canada directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a ***covered expense*** under this ***Plan.***

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

PREGNANCY

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

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

The ***Plan*** shall cover services, supplies and treatments for ***medically necessary*** abortions when the life of the mother would be endangered by continuation of the ***pregnancy,*** or when the ***pregnancy*** is the result of rape or incest.

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

BIRTHING CENTER

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

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

STERILIZATION

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

WELL NEWBORN CARE

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

Such care shall include, but is not limited to:

1. ***Physician*** services

2. ***Hospital*** services

3. Circumcision

WELL CARE

For in-network services, coverage will be provided at 100% with no patient cost sharing. Cost sharing for preventive care services rendered out-of-network will apply according to the non-network benefits of the plan. As the health care reform law changes, the list of covered services will also change. The following is a list of examples of current covered routine services which are not required due to illness or injury. For a complete list, please visit:

http://www.HealthCare.gov/law/about/provisions/services/lists.html

Please note that the preventive services listed below are not recommended for all individuals, and medical necessity criteria may be applied.

Covered Preventive Services For Adults: (19 years and older)

Abdominal Aortic Aneurysm – one time screening for men of specified ages who have ever smoked
Alcohol Misuse – screening and counseling
Blood Pressure – screening for all adults
Cholesterol – screening for adults of certain ages or at higher risk
Colorectal Cancer – screening for adults over age fifty (50)
Depression – screening for adults
Type 2 Diabetes – screening for adults with high blood pressure
Diet – counseling for adults at higher risk for chronic disease
HIV – screening for all adults at higher risk
Immunization – vaccines for adults – doses and recommended populations vary:

- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus
- Influenza (flu shot)
- Measles, Mumps, Rubella
- Meningoccal
- Pneumoccal
- Tetanus, Diptheria, Pertussis
- Varicella

Obesity – screening and counseling for adults
Sexually Transmitted Infection (STI) – prevention counseling for adults at higher risk
Tobacco Use – screening for all adults and cessation interventions for tobacco users
Syphilis – screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

Anemia – screening on a routine basis for pregnant women
Bacteriuria – urinary tract or other infection screening for pregnant women
BRCA – counseling about genetic testing for women at higher risk
Breast Cancer Mammography – screenings every one (1) to two (2) years for women over forty (40)
Breast Cancer Chemoprevention – counseling for women at higher risk
Breast Feeding – support and counseling from trained providers, as well as access to breastfeeding supplies
Cervical Cancer – screenings for sexually active women
Chlamydia Infection – screening for younger women and other women at higher risk
Contraception – FDA-approved contraceptive methods, per the following list:

- Male condom
- Female condom
- Diaphragm with spermicide
- Sponge with spermicide
- Cervical cap with spermicide
- Spermicide alone
- Oral contraceptives (progestin-only) "The Minipill"
- Combined oral contraceptives (extended/continuous use) (estrogen and progestin) "The Pill"
- Patch (estrogen and progestin)
- Vaginal contraceptive ring (estrogen and progestin)
- DMPA shot/injection (progestin)
- Emergency contraceptives “The Morning After Pill”
- Copper IUD
- IUD with Progestin
- Implantable rod (progestin)

Domestic and interpersonal violence – screening and counseling for all women
Folic Acid – supplements for women who may become pregnant
Gestational Diabetes – screening for women 24-48 weeks pregnant and those at high risk of developing gestational diabetes
Gonorrhea – screening for all women at higher risk
Hepatitis B – screening for pregnant women at their first prenatal visit
Human Immunodeficiency Virus (HIV) – screening and counseling for sexually active women*
Human Papillomavirus (HPV) DNA Test – high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
Osteoporosis – screening for women over sixty (60) depending on risk factors
Rh Incompatibility – screening for all pregnant women and follow-up testing for women at higher risk
Tobacco Use – screening and interventions for all women and expanded counseling for pregnant tobacco users
Sexually Transmitted Infections (STI) – counseling for sexually active women
Syphilis – screening for all pregnant women or other women at increased risk
Well-woman visits – to obtain recommended preventive services for women under 65

Covered Preventive Services For Children
Alcohol and Drug Use – assessments for adolescents
Autism – screening for children at eighteen (18) and twenty-four (24) months of age
Behavioral – assessments for children of all ages
Blood Pressure – screening for children ages 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years
Cervical Dysplasia – screening for sexually active females
Congenital Hypothyroidism – screening for newborns
Depression – screening for adolescents
Developmental – screening for children under age three (3), and surveillance throughout childhood
Dyslipidemia – screening for children at higher risk of lipid disorders
Fluoride Chemoprevention – supplements for children without fluoride in their water source

Gonorrhea – preventive medication for the eyes of all newborns
Hearing – screening for all newborns 0-30 days, diagnostic follow up for children to age 24 months
Height, Weight and Body Mass Index – measurements for children
Hematocrit or Hemoglobin – screening for children
Hemoglobinopathies – or sickle cell screening for newborns
HIV – screening for adolescents at higher risk
Immunization – vaccines for children from birth to age eighteen (18) – doses, recommended ages, and recommended populations vary:

- Diptheria, Tetanus, Pertussis
- Haempphilus influenza type b
- Hepatitis A
- Hepatitis B
- Human Papillomavirus
- Inactivated Poliovirus
- Influenza (flu shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

Iron – supplements for children ages six (6) to twelve (12) months at risk for anemia
Lead – screening for children at risk of exposure
Medical History – for all children throughout development
Obesity – screening and counseling
Oral Health – risk assessment for young children
Phenylketonuria (PKU) – screening for this genetic disorder in newborns
Sexually Transmitted Infection (STI) – prevention counseling for adolescents at high risk
Tuberculin – testing for children at higher risk of tuberculosis
Vision – screening for all children

THERAPY SERVICES

Therapy services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury,*** for congenital anomaly, or for prevention of continued deterioration of function. ***Covered expenses*** shall include:

1. Services of a ***professional provider*** for physical therapy. Therapy must be in accord with a ***physician's*** exact orders as to type, frequency and duration and to improve a body function.

2. Services of a ***professional provider*** for occupational therapy to improve a body function. No benefits are payable for recreational programs, maintenance therapy or supplies used in occupational therapy.

3. Services of a ***professional provider*** for speech therapy. Therapy must be ordered by a ***physician*** and follow either:

    a. surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy);
    b. an ***injury;***
    c. an ***illness*** that is other than a learning disorder**.**

4. Radiation therapy or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included. Radiation therapy and chemotherapy are subject to precertification.

5. Dialysis therapy or treatment.

6. Respiratory therapy.

7. Home infusion therapy.

EXTENDED CARE FACILITY

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

1. The ***covered person*** was first confined in a ***hospital*** for at least three (3) consecutive days;

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

3. The extended care ***confinement*** begins within fourteen (14) days after discharge from that ***hospital confinement,*** or within fourteen (14) days after a related extended care ***confinement;*** and

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

Covered expenses shall include:

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

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

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

HOME HEALTH CARE

Home health care enables the ***covered person*** to receive treatment in his home for an ***illness*** or ***injury*** instead of being confined in a ***hospital*** or ***extended care facility. Covered expenses*** shall include:

1. Part-time or intermittent nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse;

2. Physical, respiratory, occupational or speech therapy;

3. Part-time or intermittent ***home health aide services*** for a ***covered person*** who is receiving covered nursing or therapy services;

4. Medical social service consultations;

5. Nutritional guidance by a registered dietician and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary.***

HOSPICE CARE

Hospice care is a health care program providing a coordinated set of services rendered at home, in ***outpatient*** settings, or in ***facility*** settings for a ***covered person*** suffering from a condition that has a terminal prognosis.

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

1. The ***covered person*** is terminally ill, and

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

Covered expenses shall include:

1. ***Confinement*** in a ***hospice*** to include ancillary charges and ***room and board.***

2. Services, supplies and treatment provided by a ***hospice*** to a ***covered person*** in a home setting.

3. ***Physician*** services and/or nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse.

4. Physical therapy, occupational therapy, or speech therapy.

5. Nutrition services to include nutritional advice by a registered dietician, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation.

6. Counseling services provided through the ***hospice.***

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

DURABLE MEDICAL EQUIPMENT

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

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the ***covered person's*** condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the ***covered person's*** medical needs.

PROSTHESES

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a ***covered expense***. A prosthesis ordered before the ***covered person's effective date*** of coverage is not covered, even if delivered after the ***effective date*** of coverage. Repair or replacement of a prosthesis which is ***medically necessary*** due to normal use, or physiological change in the patient's condition will be considered a ***covered expense.***

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a ***covered expense***. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered. Repair or replacement of an orthotic device or appliance which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense.***

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an ***injury.*** Treatment must be rendered within twelve (12) months after the ***injury.*** Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit.

Covered expenses shall also include services, supplies and treatment for the following oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

2. Surgery needed to correct an ***injury*** to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

3. Excision of benign bony growths of the jaw and hard palate.

4. External incision and drainage of cellulitis.

5. Incision of sensory sinuses, salivary glands or ducts.

6. Removal of impacted teeth***.***

7. Reductions of dislocations and excision of temporomandibular joints (TMJs).

No benefits shall be paid for dental or oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

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

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include ***medically necessary*** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions and their administration; the initial pair of eyeglasses or contact lenses due to cataract surgery; soft lenses or sclera shells intended for use in the treatment of ***illness*** or ***injury*** of the eye; the purchase of a wig or hairpiece for hair loss following chemotherapy; surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

COSMETIC SURGERY

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

1. A ***covered person*** receives an ***injury*** as a result of an accident and, as a result requires surgery. ***Cosmetic surgery*** and treatment must be for the purpose of restoring the ***covered person*** to his normal function immediately prior to the accident.

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

MASTECTOMY

Covered expenses shall include the following:

1. ***Medically necessary*** mastectomy, including complications from a mastectomy, including lymphedemas.

2. Reconstructive breast surgery necessary because of a mastectomy.

3. Reconstructive breast surgery on the non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast.

4. External breast prosthesis and permanent internal breast prosthesis.

MENTAL AND NERVOUS DISORDERS

Inpatient or Partial Confinement

Subject to the precertification provisions of the ***Plan,*** the ***Plan*** will pay the applicable ***coinsurance*** for ***confinement*** or ***partial confinement*** in a ***hospital*** or ***treatment center*** for services, supplies and treatment related to the treatment of ***mental and nervous disorders. Physician's*** visits are limited to one (1) per day. Psychiatrists (M.D.), psychologists (Ph.D.) or counselors ((Ph.D.) may bill the ***Plan*** directly. Other licensed mental health practitioners must be under the direction of and must bill the ***Plan*** through these professionals.

Covered expenses shall include:

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

2. Individual psychotherapy;

3. Group psychotherapy;

4. Psychological testing;

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

Outpatient

The ***Plan*** will pay the applicable ***coinsurance*** for ***outpatient*** services, supplies and treatment related to the treatment of ***mental and nervous disorders. Physician's*** visits are limited to one (1) per day. Psychiatrists (M.D.), psychologists (Ph.D.) or counselors ((Ph.D.) may bill the ***Plan*** directly. Other licensed mental health practitioners must be under the direction of and must bill the ***Plan*** through these professionals.

CHEMICAL DEPENDENCY

The ***Plan*** will pay for the treatment of ***chemical dependency*** as shown on the *Schedule of Benefits.* Benefits shall be payable for ***inpatient, partial confinement*** or ***outpatient*** treatment in a ***hospital*** or ***treatment center*** by a ***physician*** or ***professional provider. Physician's*** visits are limited to one (1) per day. Psychiatrists (M.D.), psychologists (Ph.D.) or counselors ((Ph.D.) may bill the ***Plan*** directly. Other licensed mental health practitioners must be under the direction of and must bill the ***Plan*** through these professionals.

PODIATRY SERVICES

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

PRIVATE DUTY NURSING

Services of a private duty ***nurse*** (R.N., L.P.N., or L.V.N.) shall be a ***covered expense,*** provided:

1. On an ***inpatient*** basis, such care will be covered only when ***medically necessary*** and not ***custodial*** in nature. The ***hospital's intensive care unit*** must be full or the ***hospital*** must not have an ***intensive care unit,*** for services to be covered.

2. On an ***outpatient*** basis, such care must be ***medically necessary*** and not ***custodial*** in nature. ***Outpatient*** private duty nursing on a twenty-four (24) hour shift basis is not covered. ***Outpatient*** private duty nursing services are only covered as part of the ***home health care*** benefit. ***Outpatient*** private duty nursing on a twenty-four (24) hour shift basis is not covered.

Coverage for ***outpatient*** private duty nursing shall be limited as shown on the *Schedule of Benefits.*

CHIROPRACTIC CARE

Covered expense includes initial consultation, x-rays and treatment (but not maintenance care).

CARDIAC REHABILITATION PROGRAMS

Covered expenses shall include charges for ***medically necessary*** cardiac rehabilitation programs when rendered:

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

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

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

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

SLEEP DISORDERS

Covered expenses shall include charges for ***medically necessary*** sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors. The patient must exhibit a history of sleep disturbance which is having an adverse effect on the patient's health, could be potentially life-threatening or is aggravating a medical condition of the patient.

NON-SURGICAL TREATMENT OF MORBID OBESITY

Covered expenses shall include charges for non-surgical medical care in connection with weight reduction and treatment of ***morbid obesity***. For this purpose, expenses will be considered to be ***incurred*** for medical care when the patient is at least ninety (90) pounds over his or her ideal weight or twenty percent (20%) over his or her ideal weight, with a secondary condition. ***Covered expenses*** shall include non-surgical medical care and treatment, but do not include weekly maintenance or nutritional supplements for weight reduction or the treatment of obesity.

DENTAL AND EYE CARE SERVICES

Covered expenses shall include charges for dental and eye care, subject to the ***maximum benefit*** per calendar year. Expenses in excess of the ***maximum benefit*** are not covered.

PATIENT EDUCATION

Covered expenses shall include ***medically necessary*** patient education programs including, but not limited to diabetic education and ostomy care.

SURCHARGES

Any excise tax, sales tax, surcharge, (by whatever name called) imposed by a governmental entity for services, supplies and/or treatments rendered by a ***professional provider; physician; hospital; facility*** or any other health care provider shall be a ***covered expense*** under the terms of the ***Plan.***

MEDICAL EXCLUSIONS

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

1. For ***covered persons*** age nineteen (19) and older, charges for ***pre-existing conditions*** as specified in *Effective Date of Coverage, Pre-existing Conditions.*

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

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

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

5. Charges for treatment or surgery for sexual dysfunction.

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

7. Charges for biofeedback therapy.

8. Charges for services, supplies or treatments which are primarily educational in nature*;* charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

9. Charges for social or marital counseling.

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

11. Except as specified herein, charges for routine vision examinations and eye refractions; orthoptics; eyeglasses or contact lenses, except as specifically stated under *Medical Expense Benefit, Special Equipment and Supplies*; dispensing optician's services.

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

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

14. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a ***physician,*** such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-hospital adjustable beds, exercise equipment.

15. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.

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

17. Charges ***incurred*** as a result of, or in connection with, the ***pregnancy*** of a ***dependent*** child.

18. Charges for services provided to a ***covered person*** for an elective abortion. However, complications from such procedure shall be a ***covered expense*** for a covered female ***employee*** or the covered female spouse of an ***employee.***

19. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite

suppressants; Nutri/System, Weight Watchers or similar programs; and ***hospital confinements*** for weight reduction programs. However, non-surgical treatment of ***morbid obesity*** shall be a ***covered expense.***

20. Charges for surgical weight reduction procedures and all related charges, even if resulting from ***morbid obesity.***

21. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches, unless ***medically necessary*** due to a severe active lung ***illness*** such emphysema or asthma.

22. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid; charges for or in connection with a cochlear implant...

23. Charges for periodic physical examinations, such as screening examination, employment physical, or any related charges, such as premarital lab work and other care not associated with treatment or diagnosis of an ***illness*** or ***injury,*** except as specified herein.

24. Charges related to acupuncture or acupressure treatment.

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

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

27. Charges for wigs, artificial hair pieces, artificial hair transplants, or any drug - prescription or otherwise -used to eliminate baldness, except as specified under *Medical Expenses Benefit, Special Equipment and Supplies.*

28. Charges for expenses related to hypnosis or hypnotherapy**.**

29. Charges for the expenses of the donor of an organ or tissue for transplant to a recipient who is not a ***covered person*** under this ***Plan.***

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

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

32. Charges for exercise programs for treatment of any condition.

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

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

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

36. Charges for procurement and storage of one's own blood, unless ***incurred*** within three (3) months prior to a scheduled surgery.

37. Charges for homeopathic or holistic medicines or providers or naturopathy.

38. Charges for or related to the following types of treatment:

a. primal therapy;
b. rolfing;
c. psychodrama;
d. megavitamin therapy;
e. visual perceptual training.

39. Charges for structural changes to a house or vehicle.

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

41. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts.

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

43. Charges for prescription drugs that are covered under the *Prescription Drug Program* or for the Prescription Drug ***copay*** applicable thereto.

PRESCRIPTION DRUG PROGRAM

PHARMACY OPTION

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

COPAY

The ***copay*** is applied to each covered pharmacy drug charge and is shown on the S*chedule of Benefits*. The ***copay*** amount is not a ***covered expense*** under the *Medical Expense Benefit.* Any one prescription is limited to a thirty-one (31) day supply.

If a drug is purchased from a ***nonparticipating pharmacy*** or a ***participating pharmacy*** when the ***covered person's*** ID card is not used, the ***covered person*** must pay the entire cost of the prescription, including ***copay,*** and then submit the receipt to the prescription drug card vendor for reimbursement. If a ***nonparticipating pharmacy*** is used, the ***covered person*** will be responsible for the ***copay,*** plus the difference in cost between the ***participating pharmacy*** and ***nonparticipating pharmacy.***

A 90-day supply drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the pharmacy is able to offer ***covered persons*** significant savings on prescriptions. A prescription must be written by the physician for a 90-day supply.

COVERED PRESCRIPTION DRUGS

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

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

3. Insulin when prescribed by a ***physician.***

4. Contraceptives, including implants and their removal.

5. Smoking cessation patches.

6. Prescription prenatal vitamins or prescription vitamins containing fluoride.

LIMITS TO THIS BENEFIT

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

1. Refills only up to the number of times specified by a ***physician.***
/
2. Refills up to one year from the date of order by a ***physician.***

EXPENSES NOT COVERED

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin.

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

3. Immunization agents or biological sera; blood or blood plasma.

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

5. Experimental drugs and medicines, even though a charge is made to the ***covered person.***

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

7. Any drug or medicine that is consumed or administered at the place where it is dispensed.

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

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

10. A charge for appetite suppressants, nutritional supplements, dietary supplements or vitamin supplements, except for prescription prenatal vitamins or prescription vitamins containing fluoride.

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

12. A charge for drugs used to treat impotency.

13. A charge for infertility or fertility drugs.

14. A charge for Retin-A (Tretinoin) for ***covered persons*** age twenty-six (26).

PLAN EXCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18. Charges for services, supplies, care or treatment to a ***covered person*** for an ***injury*** which occurred as a result of that ***covered person's*** illegal use alcohol, except as specified in *Medical Expense Benefit, Mental and Nervous Disorders/Chemical Dependency*. Claims shall be denied if the ***Plan administrator*** has reason to believe, based on objective evidence such as police reports or medical records of the ***covered person's*** illegal use of alcohol. Expenses will be covered for injured ***covered persons*** other than the person who caused the ***injury*** due to illegal use of alcohol. This exclusion does not apply if the ***injury*** resulted from being the victim of an act of domestic violence or an underlying medical condition.

19. Charges for services, supplies, care or treatment to a ***covered person*** for an ***injury*** which occurred as a result of that ***covered person's*** illegal use (or use contrary to a ***physician's*** written instructions) of any controlled substance, drug, narcotic or hallucinogen, except as specified in *Medical Expense Benefit, Mental and Nervous Disorders/Chemical Dependency*. Claims shall be denied if the ***Plan administrator*** has reason to believe, based on objective evidence such as police reports or medical records of the ***covered person's*** illegal use (or use contrary to a ***physician's*** written instructions) of a controlled substance, drug, narcotic or hallucinogen. Expenses will be covered for injured ***covered persons*** other than the person who caused the ***injury*** due to illegal use of a controlled substance, drug, narcotic or hallucinogen or use of the controlled substance, drug, narcotic or hallucinogen contrary to a ***physician's*** written instructions. This exclusion does not apply if the ***injury*** resulted from being the victim of an act of domestic violence or an underlying medical condition.

20. Charges incurred from any intentional self-inflicted ***injury*** or ***illness***, unless the self-inflicted ***injury*** or ***illness*** is otherwise covered by the ***Plan*** and if the ***covered person's*** self-inflicted ***injury*** or ***illness*** is a result of a medical or psychiatric condition or being the victim of an act of domestic violence.

21. If the primary plan has a restricted list of healthcare providers and the ***covered person*** chooses not to use a provider from the primary plan's restricted list, this ***Plan*** will not pay for any charges disallowed by the primary plan due to the use of such provider, if shown on the primary carrier's explanation of benefits.

22. This ***Plan*** will not pay for any charge which has been refused by another plan covering the ***covered person*** as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.

ELIGIBILITY

This section identifies the ***Plan's*** requirements for a person to be eligible to enroll. Refer to *Enrollment* and *Effective Date of Coverage* for more information.

EMPLOYEE ELIGIBILITY

All ***full-time employees*** regularly scheduled to work at least thirty-five (35) hours per work week shall be eligible to enroll for coverage under this ***Plan.*** This does not include temporary or seasonal ***employees.***

Also eligible for coverage as an ***employee*** is the elected or appointed Mayor of the City of Lewisburg. The term "***employee"*** does not include common-law employees.

DEPENDENT(S) ELIGIBILITY

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

1. The term "spouse" means the spouse of the ***employee*** under a legally valid existing marriage between persons of the opposite sex, unless court ordered separation exists.

2. The term "child" means the ***employee's*** natural child, stepchild, legally adopted child, and a child for whom the ***employee*** has been appointed legal guardian, provided the child is less than twenty-six (26) years of age.

   However, a child who is eligible for group health coverage through his or her (or his or her spouse's) own employer is not eligible for coverage under this ***Plan.***

3. An eligible child shall also include any other child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan***, even if the child is not residing in the ***employee's*** household. Such child shall be referred to as an ***alternate recipient***. ***Alternate recipients*** are eligible for coverage regardless of whether the ***employee*** elects coverage for himself. An application for enrollment must be submitted to the ***employer*** for coverage under this ***Plan***. The ***employer/plan administrator*** shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the ***Plan*** pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the ***employer/plan administrator*** shall determine whether such order is a Qualified Medical Child Support Order (as defined in Section 609 of ERISA) or a National Medical Support Notice (NMSN) as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

   The ***employer/plan administrator*** reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

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

5. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the ***employee*** for support due to a mental and/or physical disability, and who was covered under the ***Plan*** prior to reaching the

maximum age limit or other loss of ***dependent's*** eligibility, will remain eligible for coverage under this ***Plan*** beyond the date coverage would otherwise be lost.

Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the ***employer*** or ***claims processor,*** but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

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

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

Every eligible ***employee*** may enroll eligible ***dependents.*** However, if both the husband and wife are ***employees,*** they may choose to have one covered as the ***employee,*** and the spouse covered as the ***dependent*** of the ***employee,*** or they may choose to have both covered as ***employees.*** Eligible children may be enrolled as ***dependents*** of one spouse, but not both.

ENROLLMENT

APPLICATION FOR ENROLLMENT

An ***employee*** must file a written application with the ***employer*** for coverage hereunder for himself and his eligible ***dependents*** within thirty-one (31) days of becoming eligible for coverage; and within thirty-one (31) days of marriage or the acquiring of children or birth of a child. The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder.

The ***employer*** must be notified of any change in eligibility of ***dependents,*** including the birth of a child that is to be covered and adding or deleting any other ***dependents.*** Forms are available from the ***employer*** for reporting changes in ***dependents'*** eligibility as required.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

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

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

2. Cessation of employer contributions toward the other coverage

3. Legal separation or divorce

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

5. Death of ***covered person.***

6. Moving out of an HMO service area.

7. A child losing ***dependent*** status.

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

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

The ***employee*** or ***dependent*** must request the special enrollment and enroll no later than thirty-one (31) days from the date of loss of other coverage.

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

SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)

An ***employee*** who is not covered under the ***Plan***, but who acquires a new ***dependent*** may request a special enrollment period. For the purposes of this provision, the acquisition of a new ***dependent*** includes:

- marriage
- birth of a ***dependent*** child
- adoption or ***placement for adoption*** of a ***dependent*** child

The ***employee*** must request the special enrollment within thirty-one (31) days of the acquisition of the ***dependent.***

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

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

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

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

SPECIAL ENROLLMENT PERIOD (MEDICAID OR CHIP)

An ***employee*** or ***dependent*** that is otherwise eligible for coverage under this ***Plan***, but not enrolled, may be eligible for a Special Enrollment Period if either of the following conditions is met:

1. The ***employee*** or ***dependent*** is covered under a Medicaid program under Title XIX of the Social Security Act or under a state child health plan (CHIP) under Title XXI of the Act, and coverage under such plan or program is terminated because the ***employee*** **or** ***dependent*** loses eligibility.

2. The ***employee*** or ***dependent*** is determined by the state to be eligible to receive contribution assistance from a Medicaid program or state child health plan, to pay for coverage under this ***Plan.***

However, loss of eligibility does not include a loss of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage.)

The ***employee*** or ***dependent*** must request the special enrollment and enroll no later than sixty (60) days from the date of termination of Medicaid or CHIP coverage or sixty (60) days from **the date the individual is determined to be eligible for contribution assistance by the state of residence.**

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

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If the ***covered person*** is eligible for health coverage from the ***employer***, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If the ***employee*** or his or her ***dependents*** are already enrolled in Medicaid or CHIP and you live in a State listed below, they can contact their State Medicaid or CHIP office to find out if premium assistance is available.

If the ***employee*** or their ***dependents*** are NOT currently enrolled in Medicaid or CHIP, and thinks they or any of their ***dependents*** might be eligible for either of these programs, they may contact their State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If a ***covered person*** qualifies, they can ask the State if it has a program that might help pay the premiums for an employer-sponsored plan.

Once it is determined that the ***covered person*** is eligible for premium assistance under Medicaid or CHIP, the ***Plan*** is required to permit the ***covered person***s to enroll in the ***Plan*** – as long as they are eligible, but not already enrolled in the ***Plan***. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. See *Enrollment, Special Enrollment (Medicaid or CHIP).*

If the *covered person* lives in one of the following States, they may be eligible for assistance paying their employer health plan premiums. The following list of States is current as of January 22, 2010. Contact the state of residence for further information on eligibility –

<table>
<tr><td>ALABAMA – Medicaid</td><td>CALIFORNIA – Medicaid</td></tr>
<tr><td>Website: http://www.medicaid.alabama.gov
Phone: 1-800-362-1504</td><td>Website: http://www.dhcs.ca.gov/ Pages/ default.aspx
Phone: 1-800-635-2570</td></tr>
<tr><td>ALASKA – Medicaid</td><td>COLORADO – Medicaid and CHIP</td></tr>
<tr><td>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529</td><td rowspan="3">Medicaid Website: http://www.colorado.gov/
Medicaid Phone: 1-800-866-3513
CHIP Website: http:// www.CHPplus.org
CHIP Phone: 303-866-3243</td></tr>
<tr><td>ARIZONA – CHIP</td></tr>
<tr><td>Website: http://www.azahcccs.gov/applicants/default.aspx
Phone: 602-417-5422</td></tr>
<tr><td>ARKANSAS – CHIP</td><td>FLORIDA – Medicaid</td></tr>
<tr><td>Website: http://www.arkidsfirst.com/
Phone: 1-888-474-8275</td><td>Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml
Phone: 1-866-762-2237</td></tr>
<tr><td>GEORGIA – Medicaid</td><td>MONTANA – Medicaid</td></tr>
<tr><td>Website: http://dch.georgia.gov/
Click on Programs, then Medicaid
Phone: 1-800-869-1150</td><td>Website: http://medicaidprovider.hhs.mt.gov/clientpages/ clientindex.shtml
Telephone: 1-800-694-3084</td></tr>
<tr><td>IDAHO – Medicaid and CHIP</td><td>NEBRASKA – Medicaid</td></tr>
<tr><td>Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 208-334-5747
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588</td><td>Website: http://www.dhhs.ne.gov/med/medindex.htm
Phone: 1-877-255-3092</td></tr>
</table>

INDIANA – Medicaid Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	**NEVADA** – Medicaid and CHIP Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid Website: https://www.khpa.ks.gov Phone: 1-800-635-2570	**NEW HAMPSHIRE** – Medicaid Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	**NEW JERSEY** – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid Website: www.dhh.louisiana.gov/offices/?ID=92 Phone: 1-888-342-0555	
MAINE – Medicaid Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	**NEW MEXICO –** Medicaid and CHIP Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 800-657-3739	**NEW YORK –** Medicaid Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	**NORTH CAROLINA** – Medicaid Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	**UTAH** – Medicaid Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414

OKLAHOMA – Medicaid	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Medicaid Website: http://www.oregon.gov/DHS/healthplan/index.shtml Medicaid Phone: 1-800-359-9517 CHIP Website: http://www.oregon.gov/DHS/healthplan/app_benefits/ohp4u.shtml CHIP Phone: 1-800-359-9517	Medicaid Website: http://www.famis.org/ Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://ihrsa/sites/DCS/COB/default.aspx Phone: 1-800-562-6136
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since January 22, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OPEN ENROLLMENT

Open enrollment is the period designated by the ***employer*** during which the ***employee*** may elect coverage for himself and any eligible ***dependents*** if he is not covered under the ***Plan*** and does not qualify for a Special Enrollment as described herein. An open enrollment will be permitted once in each calendar year during the month of February. ***Employees*** or ***dependents*** who enroll in the ***Plan*** during an open enrollment are considered ***late enrollees***.

During this open enrollment period, an ***employee*** and his ***dependents*** who are not covered under this ***Plan*** must complete and submit an enrollment form for coverage. Coverage shall be effective on the following March 1st.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE(S) EFFECTIVE DATE

Eligible ***employees,*** as described in *Eligibility,* are covered under the ***Plan*** on the date of hire.

DEPENDENT(S) EFFECTIVE DATE

Eligible ***dependent(s),*** as described in *Eligibility,* will become covered under the ***Plan*** on the later of the dates listed below, provided the ***employee*** has enrolled them in the ***Plan*** within thirty-one (31) days of meeting the ***Plan's*** eligibility requirements.

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

2. The date the ***dependent*** is acquired, provided any required contributions are made and the ***employee*** has applied for ***dependent*** coverage within thirty-one (31) days of the date acquired.

3. Newborn children shall be covered from birth, regardless of ***confinement,*** provided the ***employee*** has applied for ***dependent*** coverage within thirty-one (31) days of birth.

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

PRE-EXISTING CONDITIONS

Benefits will be provided for ***pre-existing conditions*** after the completion of a period of twelve (12) months (eighteen (18) months for a late enrollee) from the ***covered person's*** date of enrollment for coverage under this ***Plan.*** For the purpose of this provision, the date of enrollment shall mean the first day of any applicable service waiting period or the date of hire. In the case of a Special or ^C Open Enrollment, the enrollment date shall mean the first day of coverage.

This ***pre-existing condition*** limitation shall not apply to a child born to or ***placed for adoption*** after the ***employee's effective date*** of coverage under this ***Plan,*** nor to ***pregnancy*** under any circumstances. In addition, ***pre-existing condition*** limitations do **NOT** apply to any ***covered person*** under age nineteen (19).

Precertification from the ***Utilization Review Organization*** does not constitute ***Plan*** liability for any ***pre-existing condition*** charges during this waiting period.

For the purpose of determining whether this ***pre-existing condition*** provision of the ***Plan*** will be applied to claims for any individual, the ***Plan administrator*** will look not only to the period of time the individual has been covered under this ***Plan,*** but also to any period of previous creditable coverage the individual has earned. Creditable coverage shall include, but is not limited to, coverage the individual may have had under a prior employer's benefit plan or COBRA, individual or group insurance, Medicare or Medicaid, a state risk pool, or TriCare. Other types of coverage may also be considered creditable coverage. However, creditable coverage will only be applied to this ***Plan's pre-existing condition*** time periods if there has been no break in coverage of the individual for sixty-three (63) days or more. If there has been a break in coverage of sixty-three (63) days or more, the ***Plan administrator*** will not apply previous coverage towards this ***Plan's pre-existing condition*** limitation. Waiting periods for coverage do not count as a break in coverage.

It is the ***employee's*** responsibility to provide the ***Plan administrator*** with evidence of creditable coverage. Such evidence may be in the form of a Certificate of Coverage or in any other form acceptable to the ***Plan administrator.***

TERMINATION OF COVERAGE

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

EMPLOYEE(S) TERMINATION DATE

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

2. The date the ***employee*** ceases to meet the eligibility requirements of the ***Plan.***

3. The date employment terminates.

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

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

DEPENDENT(S) TERMINATION DATE

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

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

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

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

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

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

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents,*** when the ***employee*** is on an authorized ***leave of absence*** from the ***employer.*** In no event will coverage continue beyond the end of the thirty (30) day period that follows the end of the calendar month in which the ***employee's*** active service ends.

LAYOFF

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents,*** when the ***employee*** is subject to an ***employer layoff.*** In no event will coverage continue beyond the end of the thirty (30) day period that follows the end of the calendar month in which the ***employee's*** active service ends.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An ***employee*** who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this ***Plan*** for up to twelve (12) weeks during any twelve (12) month period. An ***employee*** may be eligible for up to twenty-six (26) weeks of Family and Medical Leave Act leave during a twelve (12) month period if such leave is required to care for a family member who is injured or ill as the result of active duty in the military.

Contributions

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

Reinstatement

If coverage under the ***Plan*** was terminated during an approved FMLA leave, and the ***employee*** returns to active work immediately upon completion of that leave, ***Plan*** coverage will be reinstated on the date the ***employee*** returns to active work as if coverage had not terminated, provided the ***employee*** makes any necessary contributions and enrolls for coverage within thirty-one (31) days of his return to active work.

Repayment Requirement

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

CERTIFICATES OF COVERAGE

The ***Plan administrator*** shall provide each terminating ***covered person*** with a Certificate of Coverage, certifying the period of time the individual was covered under this ***Plan.*** For ***employees*** with ***dependent*** coverage, the certificate provided may include information on all covered ***dependents.*** This ***Plan*** will at all times comply with the provisions of the Health Insurance Portability and Accountability Act of 1996.

CONTINUATION OF COVERAGE

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

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

QUALIFYING EVENTS

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

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

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

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

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

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

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

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

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered ***employee,*** or a child's loss of ***dependent*** status, the ***employee*** or ***dependent*** must notify the Human Resources Department of the ***employer,*** in writing, of that event within **sixty (60)** days of the event**.** The ***employee*** or ***dependent*** must advise the date and nature of the qualifying event and the name, address and Social Security number of the affected individual. **Failure to provide such notice to the *employer* will result in the person forfeiting their rights to continuation of coverage under this provision.**

2. Within fourteen (14) days of a qualifying event, or within fourteen (14) days of receiving notice of a qualifying event, the ***employee*** or ***dependent*** will be notified of his rights to continuation of coverage, and what process is required to elect continuation of coverage.

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

election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the latter of the following:

a. The date coverage under the ***Plan*** would otherwise end; or
b. The date the person receives the notice from the ***employer*** of his or her rights to continuation of coverage.

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

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

COST OF COVERAGE

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

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

WHEN CONTINUATION COVERAGE BEGINS

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

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

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

SUBSEQUENT QUALIFYING EVENTS

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

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

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

3. ***Employee's*** entitlement to ***Medicare*** if it results in a loss of coverage under this ***Plan.***

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

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

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

END OF CONTINUATION

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

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

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

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

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

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

6. The date the ***covered person*** first becomes covered under any other group health plan after the date of election of COBRA continuation coverage, with exception of the ***pre-existing*** provision below.

SPECIAL RULES REGARDING NOTICES

1. Any notice required in connection with continuation coverage under this ***Plan*** must, at minimum, contain sufficient information so that the ***plan administrator*** (or its designee) is able to determine from such notice the ***employee*** and ***dependent(s)*** (if any), the qualifying event or disability, and the date on which the qualifying event occurred.

2. In connection with continuation coverage under this ***Plan,*** any notice required to be provided by any individual who is either the ***employee*** or a ***dependent*** with respect to the qualifying event may be provided by a representative acting on behalf of the ***employee*** or the ***dependent,*** and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.

3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:

    (a) A single notice addressed to both the ***employee*** or the spouse will be sufficient as to both individuals if, on the basis of the most recent information available to the ***Plan,*** the spouse resides at the same location as the ***employee;*** and

(b) A single notice to the ***employee*** or the spouse will be sufficient as to each ***dependent*** child of the ***employee*** if, on the basis of the most recent information available to the ***Plan,*** the ***dependent*** child resides at the same location as the individual to whom such notice is provided.

PRE-EXISTING CONDITIONS

In the event that a ***covered person*** becomes eligible for coverage under another employer-sponsored group health plan, and that group health plan has an exclusion or ***pre-existing*** limitation on a condition that is covered by this ***Plan,*** the ***covered person*** may remain covered under this ***Plan*** with continuation of coverage and elect coverage under the other employer's group health plan. This ***Plan*** shall be primary payor for the ***covered expenses*** that are excluded or limited under the other employer sponsored group health plan and secondary payor for all other expenses.

EXTENSION FOR DISABLED INDIVIDUALS

A person who is ***totally disabled*** may extend continuation coverage from eighteen (18) months to twenty-nine (29) months. The person must be disabled for Social Security purposes at the time of the qualifying event or within sixty (60) days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the ***employer*** within the initial eighteen (18) month continuation coverage period and no later than sixty (60) days after the Social Security Administration's determination. The ***employer*** may charge 150% of the contribution during the additional eleven (11) months of continuation of coverage.

MILITARY MOBILIZATION

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

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

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

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

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

The ***employee's*** coverage will be reinstated without exclusions or a waiting period.

CLAIM FILING PROCEDURE

A claim for benefits is any request for a benefit that is provided by this ***Plan*** made by a ***covered person*** or the ***authorized representative*** of a ***covered person*** which complies with the ***Plan's*** procedures for making claims. Claims for health care benefits are one of two types: ***pre-service claims*** or ***post-service*** claims.

Pre-service claims are claims for services for which preapproval must be received before services are rendered in order for benefits to be payable under this ***Plan***, such as those services listed in the section *Utilization Review*. A ***pre-service claim*** is considered to be filed whenever the initial contact or call is made by the ***covered person,*** provider or ***authorized representative*** to the ***Utilization Review Organization,*** as specified in *Utilization Review.*

Post-service claims are those for which services have already been received (any claims other than ***pre-service claims***)***.***

If the ***covered person*** would like the ***Plan administrator/claims processor*** to deal with someone other than them regarding a claim for benefits then the ***covered person*** must provide the ***Plan administrator*** with a written authorization in order for an ***authorized representative*** (other than the ***employee***) to represent and act on behalf of the ***covered person.*** The ***covered person*** must consent to release information related to the claim to the ***authorized representative.***

FILING A PRE-SERVICE CLAIM

A ***pre-service claim*** begins when the ***covered person,*** provider, or the ***covered person's authorized representative*** makes a call to the ***Utilization Review Organization*** to precertify specified services, supplies or treatment. See *Utilization Review* for specific details regarding the services that require precertification, the number to call, and time frames for making the precertification call.

If a call is made to the ***Utilization Review Organization*** that fails to follow the precertification procedure as specified in *Utilization Review*, but at least identifies the name of the patient, a specific medical condition or symptom and the specific treatment, service or product for which precertification is being requested, the ***covered person*** or the ***covered person's authorized representative*** will be orally notified (in writing, if requested) within five (5) calendar days (twenty-four (24) hours in the case of Urgent Care Claims) of the failure to follow correct procedures.

Pre-service claims fall into three categories: Precertification Claims, Urgent Care Claims or Concurrent Care Claims.

A. A Precertification Claim is a claim for any services for which the ***Plan*** requires precertification, however the services that are required are not services which would qualify as Urgent Care Claims, as defined below.

B. Urgent Care Claims are claims for services which require precertification, however, the services are of such a nature such that the application of the longer time periods for making Precertification Claim determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or – in the opinion of a ***physician*** with knowledge of the patient's medical condition – would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

C. Concurrent Care Claims are claims for continuing care for which additional services are being requested or claims for which benefits for additional care are being reduced or terminated.

TIME FRAME FOR BENEFIT DETERMINATION OF A PRE-SERVICE CLAIM

When a ***pre-service claim*** has been submitted to the ***Plan*** (call made to the ***Utilization Review Organization***) and no additional information is required, the ***Plan*** will generally complete its determination of the claim within the following timeframes:

1. Precertification Claims – within a reasonable time frame, but no later than fifteen (15) calendar days from receipt of claim;

2. Urgent Care Claims – within a reasonable time frame, but no later than seventy-two (72) hours following receipt of claim;

3. Concurrent Care Claims – if a request for an extension of an on-going course of treatment is received, determination will be made as follows:

    a. If the request for additional care is of an urgent care nature and the request is made at least twenty-four (24) hours prior to the end of the course of treatment, the determination must be made within twenty-four (24) hours of the request. If the request is made less than twenty-four (24) hours prior to the end of the course of treatment, the determination must be made within seventy-two (72) hours of the request;

    b. For non-urgent care, the determination must be made within fifteen (15) calendar days after the request is received.

When a ***pre-service claim*** has been submitted to the ***Plan*** and additional information is needed in order to determine whether and to what extent, services are covered or benefits are payable by the ***Plan,*** then the ***Plan administrator*** or its designee (***Utilization Review Organization***), shall notify the ***covered person*** as follows:

1. If the ***pre-service*** claim is for care of an urgent care nature, the ***Plan administrator*** or its designee shall notify the ***covered person*** as soon as possible, but no later than twenty-four (24) hours after the initial call, of the specific information necessary to complete the claim. The ***covered person*** or ***authorized representative*** will have forty-eight (48) hours to provide the requested information and the ***Plan administrator*** or its designee will complete the claim determination no later than forty-eight (48) hours after receipt of the requested information. Failure of the ***covered person*** to respond in a timely and complete manner will result in a denial of the precertification request.

2. If the ***pre-service claim*** is for non-urgent care or if an extension of time is required due to reasons beyond the control of the ***Plan administrator*** or its designee***,*** the ***Plan administrator*** or its ***designee*** will, within fifteen (15) calendar days from the date of the initial call, provide the ***covered person*** or the ***covered person's authorized representative*** with a notice detailing the circumstances and the date by which the ***Plan administrator,*** or its designee, expects to render a decision. If additional information is required, the notice will provide details of what information is needed and the ***covered person*** will have forty-five (45) days to provide the requested information. The ***Plan administrator,*** or its designee, will complete its determination of the claim no later than fifteen (15) calendar days following receipt of the requested information. Failure to respond in a timely and complete manner will result in a denial of the precertification request.

NOTICE OF PRE-SERVICE CLAIM BENEFIT DENIAL

If the ***pre-service claim*** for benefits is denied, the ***Plan administrator*** or its designee shall provide the ***covered person*** or authorized representative with a written notice of benefit denial within the timeframes listed above.

The notice will contain the following:

A. Explanation of the denial, including:

1. The specific reasons for the denial;
2. Reference to the ***Plan*** provisions on which the denial is based;
3. A description of any additional material or information necessary and an explanation of why such material or information is necessary;
4. A description of the ***Plan's*** review procedure and applicable time limits;
5. A statement that if the ***covered person's*** appeal (See "Appealing a Denied Claim" below) is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

B. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice will contain either

1. A copy of that criterion, or
2. A statement that such criterion was relied upon and will be supplied free of charge, upon request

C. If denial was based on ***medical necessity***, ***experimental*** treatment or similar exclusion or limit, the ***Plan*** will supply either

1. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
2. A statement that such explanation will be supplied free of charge, upon request

APPEALING A DENIED PRE-SERVICE CLAIM

The Named Fiduciary for purposes of an appeal of a ***pre-service claim*** as described in U. S. Department of Labor Regulations 2560.503-1 is the ***Utilization Review Organization***.

A ***covered person,*** or the ***covered person's authorized representative***, may request a review of a denied claim by making written (for any claim involving urgent care, the request may be verbal) request to the Named Fiduciary within one hundred eighty (180) calendar days from receipt of notification of the denial. The written request should state the reasons the ***covered person*** feels the claim should not have been denied. The following describes the review process:

1. The ***covered person*** has a right to submit documents, information and comments

2. The ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits. Relevant information is defined as any document, record or other information.

   a. Relied on in making the benefit determination; or
   b. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
   c. That demonstrates compliance with the duties to make benefit decisions in accordance with plan documents and to make consistent decisions; or

d. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

3. The review shall take into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

4. The review by the Named Fiduciary will not afford deference to the original denial.

5. The Named Fiduciary will not be

   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim

6. If the original denial was, in whole or in part, based on medical judgment:

   a. The Named Fiduciary will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.
   b. The ***professional provider*** utilized by the Named Fiduciary will be neither
      (1) An individual who was considered in connection with the original denial of the claim, nor
      (2) A subordinate of any other ***professional provider*** who was considered in connection with the original denial.
   c. If requested, the Named Fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION FOR PRE-SERVICE CLAIMS ON APPEAL

The Named Fiduciary shall provide the ***covered person*** or authorized representative with a written notice of the appeal decision within the following timeframes:

1. Urgent Care Claims or Concurrent Care Claims involving urgent care – as soon as possible, but not later than seventy-two (72) hours from receipt of appeal;

2. Precertification Claims or Concurrent Care Claims involving non-urgent care – as soon as possible, but not later than fifteen (15) calendar days from receipt of appeal;

If the appeal is denied, the notice will contain the following:

A. Explanation of the denial including:

   1. The specific reasons for the denial
   2. Reference to specific ***Plan*** provisions on which the denial is based
   3. A statement that the ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits.
   4. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

B. If an internal rule, guideline, protocol or other similar criterion was relied upon the Notice will contain either:

   1. A copy of that criterion, or

2. A statement that such criterion was relied upon and will be supplied free of charge, upon request

C. If the denial was based on ***medical necessity***, ***experimental*** treatment or similar exclusion or limit, the Notice will supply either:

1. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
2. A statement that such explanation will be supplied free of charge, upon request

FILING A POST-SERVICE CLAIM

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

   Claims should be submitted to the address shown on the ***covered person's*** identification card.

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

   a. Name of patient.
   b. Patient's date of birth.
   c. Name of ***employee.***
   d. Address of ***employee.***
   e. Name of ***employer.***
   f. Name, address and tax identification number of provider.
   g. ***Employee*** Social Security number.
   h. Date of service.
   i. Diagnosis.
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the accident***, injury*** or ***illness*** being treated.

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

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

TIME FRAME FOR BENEFIT DETERMINATION OF A POST-SERVICE CLAIM

When a completed claim has been submitted to the ***claims processor*** and no additional information is required, the ***claims processor*** will generally complete its determination of the claim within thirty (30) calendar day of receipt of the completed claim, unless an extension of time is necessary due to circumstances beyond the ***Plan's*** control.

When a completed claim has been submitted to the ***claims processor*** and additional information is required for determination of the claim, the ***claims processor*** will provide the ***covered person*** or ***authorized representative*** with a notice detailing the information needed. This notice will be provided within thirty (30) calendar days of receipt of the completed claim and will indicate the date when the ***claims processor*** expects to make a decision, if the requested information is received. The ***covered person*** will have forty-five (45) calendar days to provide the information requested, and the ***claims processor*** will complete its determination of the claim within fifteen (15) calendar days of

receipt of the requested information**.** Failure to respond in a timely and complete manner will result in a denial of benefit payment.

NOTICE OF POST-SERVICE CLAIM BENEFIT DENIAL

If the ***post-service*** claim for benefits is denied, the ***Plan administrator*** or their designee shall provide the ***covered person*** or ***authorized representative*** with a written notice of benefit denial within thirty (30) calendar days of receipt of a completed claim, or if the ***Plan*** had requested additional information from the ***covered person*** or ***authorized representative***, within fifteen (15) calendar days of receipt of such information. The notice will contain the following:

A. Explanation of the denial, including:

1. The specific reasons for the denial;
2. Reference to the ***Plan*** provisions on which the denial is based
3. A description of any additional material or information necessary and an explanation of why such material or information is necessary
4. A description of the ***Plan's*** review procedure and applicable time limits
5. A statement that if the ***covered person's*** appeal (See "Appealing a Denied Claim" below) is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

B. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice will contain either

1. A copy of that criterion, or
2. A statement that such criterion was relied upon and will be supplied free of charge, upon request

C. If the denial was based on ***medical necessity***, ***experimental*** treatment or similar exclusion or limit, the ***Plan*** will supply either

1. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
2. A statement that such explanation will be supplied free of charge, upon request

APPEALING A DENIED POST-SERVICE CLAIM

The "Named Fiduciary" for purposes of an appeal of a ***post-service claim*** as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000) is the ***claims processor***.

A ***covered person,*** or the ***covered person's authorized representative***, may request a review of a denied claim by making written request to the "Named Fiduciary" within one hundred eighty (180) calendar days from receipt of notification of the denial. The request for review should state the reasons the ***covered person*** feels the claim should not have been denied.

The review process is as follows:

1. The ***covered person*** has a right to submit documents, information and comments

2. The ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits. Relevant information is defined as any document, record or other information:

   a. Relied on in making the benefit determination, OR

b. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon, OR
c. That demonstrates compliance with the duties to make benefit decisions in accordance with plan documents and to make consistent decisions, OR
d. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

3. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

4. The review by the Named Fiduciary will not afford deference to the original denial.

5. The Named Fiduciary will not be

a. The individual who originally denied the claim, nor
b. Subordinate to the individual who originally denied the claim

6. If original denial was, in whole or in part, based on medical judgment,

a. The Named Fiduciary will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.
b. The ***professional provider*** utilized by the Named Fiduciary will be neither
(1) An individual who was considered in connection with the original denial of the claim, nor
(2) A subordinate of any other ***professional provider*** who was considered in connection with the original denial.
c. If requested, the Named Fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION FOR POST-SERVICE CLAIM APPEAL

The ***Plan administrator*** or their designee shall provide the ***covered person*** or ***authorized representative*** with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal. If the appeal is denied, the notice will contain the following:

A. An explanation of the denial including:

1. The specific reasons for the denial
2. Reference to specific ***Plan*** provisions on which the denial is based
3. A statement that the ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits.
4. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

B. If an internal rule, guideline, protocol or other similar criterion was relied upon the Notice will contain either:

1. A copy of that criterion, or
2. A statement that such criterion was relied upon and will be supplied free of charge, upon request

C. If the denial was based on ***medical necessity***, ***experimental*** treatment or similar exclusion or limit, will supply either

1. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the patient's medical circumstances, or
2. A statement that such explanation will be supplied free of charge, upon request.

FOREIGN CLAIMS

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

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

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

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

COORDINATION OF BENEFITS

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

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

DEFINITIONS APPLICABLE TO THIS PROVISION

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

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

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

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

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

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

3. A licensed Health Maintenance Organization (HMO);

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

5. Group automobile insurance;

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

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

8. Labor/management trusteed, union welfare, employer organization, or employee benefit organization plans.

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

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

EFFECT ON BENEFITS

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

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

AUTOMOBILE LIMITATIONS

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

ORDER OF BENEFIT DETERMINATION

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

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

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

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

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

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

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

6. Limited Continuation of Coverage
If a person is covered under another group health plan, but is also covered under this ***Plan*** for continuation of coverage due to the Other Plan's limitation for ***pre-existing conditions*** or exclusions, the Other Plan shall be primary for all ***covered expenses*** which are not related to the ***pre-existing condition*** or exclusions. This ***Plan*** shall be primary for the ***pre-existing condition*** only.

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

LIMITATIONS ON PAYMENTS

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

FACILITY OF BENEFIT PAYMENT

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

SUBROGATION

The ***Plan*** is designed to only pay ***covered expenses*** for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a ***covered person*** in a time of need, however, the ***Plan*** may pay ***covered expenses*** that may be or become the responsibility of another person, provided that the ***Plan*** later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the ***Plan***, as well as by applying for payment of ***covered expenses***, a ***covered person*** is subject to, and agrees to, the following terms and conditions with respect to the amount of ***covered expenses*** paid by the ***Plan***:

1. Assignment of Rights (Subrogation). The ***covered person*** automatically assigns to the ***Plan*** any rights the ***covered person*** may have to recover all or part of the same ***covered expenses*** from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the ***Plan***. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a ***covered person*** or paid to another for the benefit of the ***covered person***. This assignment applies on a first-dollar basis (*i.e.*, has priority over other rights), applies whether the funds paid to (or for the benefit of) the ***covered person*** constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the ***Plan*** to pursue any claim that the ***covered person*** may have, whether or not the ***covered person*** chooses to pursue that claim. By this assignment, the ***Plan's*** right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The ***Plan*** shall have an equitable lien against any rights the ***covered person*** may have to recover the same ***covered expenses*** from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the ***Plan***. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid ***covered expenses*** prior to a determination that the ***covered expenses*** arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the ***covered person***, the ***covered person's*** attorney, and/or a trust) as a result of an exercise of the ***covered person's*** rights of recovery (sometimes referred to as "proceeds"). The ***Plan*** shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the ***Plan administrator***, the ***Plan*** may reduce any future ***covered expenses*** otherwise available to the ***covered person*** under the ***Plan*** by an amount up to the total amount of Reimbursable Payments made by the ***Plan*** that is subject to the equitable lien.

   This and any other provisions of the ***Plan*** concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the ***Plan*** concerning subrogation, equitable liens and other equitable remedies are also intended to supercede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in ***Plan's*** Reimbursement Activities. The ***covered person*** has an obligation to assist the ***Plan*** to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the ***covered person***, and to provide the ***Plan*** with any information concerning the ***covered person's*** other insurance coverage

(whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the ***covered person***. The ***covered person*** is required to (a) cooperate fully in the ***Plan's*** (or any ***Plan*** fiduciary's) enforcement of the terms of the ***Plan***, including the exercise of the ***Plan's*** right to subrogation and reimbursement, whether against the covered person or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the ***Plan*** as a co-payee for the amount of the Reimbursable Payments and notifying the ***Plan***), (c) sign any document deemed by the ***Plan administrator*** to be relevant to protecting the ***Plan's*** subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the ***Plan administrator*** or ***claims processor*** to enforce the ***Plan***'s rights.

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

THIS PLAN AND MEDICARE

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

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

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

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

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

This section is subject to the terms of the ***Medicare*** laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

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

The ***Plan administrator*** is the named fiduciary of the ***Plan*** for all purposes except claim appeals, as specified in *Claim Filing Procedure.* As fiduciary, the ***Plan administrator*** maintains discretionary authority with respect to those responsibilities for which it has been designated named fiduciary, including, but not limited to, interpretation of the terms of the ***Plan,*** and determining eligibility for and entitlement to ***Plan*** benefits in accordance with the terms of the ***Plan;*** any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ASSIGNMENT

The ***Plan*** will pay benefits under this ***Plan*** to the ***employee*** unless payment has been assigned to a ***hospital, physician,*** or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the ***Plan*** unless the ***claims processor*** is notified in writing of such assignment prior to payment hereunder.

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

This ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a qualified medical child support order.

BENEFITS NOT TRANSFERABLE

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

CLERICAL ERROR

No clerical error on the part of the ***employer*** or ***claims processor*** shall operate to defeat any of the rights, privileges, services, or benefits of any ***employee*** or any ***dependent(s)*** hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

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

EFFECTIVE DATE OF THE PLAN

The original ***effective date*** of this ***Plan*** was March 1, 2008. The ***effective date*** of the modifications contained herein is March 1, 2013.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

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

INCAPACITY

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

INCONTESTABILITY

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

LEGAL ACTIONS

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

LIMITS ON LIABILITY

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

LOST DISTRIBUTEES

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

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

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

MISREPRESENTATION

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

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

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

PLAN IS NOT A CONTRACT

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

PLAN MODIFICATION AND AMENDMENT

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

Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***employer,*** or a written copy thereof shall be deposited with such master copy of the ***Plan.*** Appropriate filing and reporting of any such modification or amendment with governmental authorities and to ***covered persons*** shall be timely made by the ***employer.***

PLAN TERMINATION

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

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

PRONOUNS

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

RECOVERY FOR OVERPAYMENT

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

RESCISSION OF COVERAGE

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

STATUS CHANGE

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

TIME EFFECTIVE

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

WORKERS' COMPENSATION NOT AFFECTED

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

DEFINITIONS

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

Alternate Recipient

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

Ambulatory Surgical Facility

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

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

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

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

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

Authorized Representative

An individual who the ***covered person*** has authorized (in writing) to represent or act on their behalf with regards to a claim. An assignment of benefits does not constitute a written authorization for a provider to act as an ***authorized representative*** of a ***covered person.***

Birthing Center

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

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

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

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

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

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

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

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

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

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

Chemical Dependency

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

Chiropractic Care

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

Claims Processor

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

Close Relative

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

Coinsurance

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

Complications of Pregnancy

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

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

2. Ectopic ***pregnancy.***

3. Toxemia with convulsions (Eclampsia).

4. Pernicious vomiting (hyperemesis gravidarum).

5. Nephrosis.

6. Cardiac Decompensation.

7. Missed Abortion.

8. Miscarriage.

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

Concurrent Review

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

Confinement

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

Copay

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

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Covered Expenses

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

Covered Person

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

Custodial Care

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

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

Customary and Reasonable Amount

The fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is ***incurred*** and is comparable in severity and nature to the ***illness*** or ***injury.*** Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. The ***customary and reasonable amount*** is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges.

Dependents

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

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;

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

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

4. Is appropriate for use in the home.

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

Effective Date

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

Emergency

The sudden onset of an ***illness*** or ***injury*** where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

1. Placing the ***covered person's*** life in jeopardy, or

2. Causing other serious medical consequences, or

3. Causing serious impairment to bodily functions, or

4. Causing serious dysfunction of any bodily organ or part.

Employee

A person directly involved in the regular business of and compensated for services by the ***employer,*** who is regularly scheduled to work not less than thirty-five (35) hours per work week on a ***full-time*** status basis or the elected or appointed Mayor of Lewisburg.

Employer

The ***employer*** is City of Lewisburg.

Experimental/Investigational

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

The ***claims processor,*** Named Fiduciary, ***Plan administrator*** or their designee must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The ***claims processor,*** Named Fiduciary, ***Plan administrator*** or their designee shall be guided by a reasonable interpretation of ***Plan*** provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The ***claims processor,*** Named Fiduciary, ***Plan administrator*** or their designee will be guided by the following principles:

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

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

3. If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is in the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety its efficacy as compared with a standard means of treatment or diagnosis; or

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

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

Extended Care Facility

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

1. It is licensed to provide, and is engaged in providing, on an ***inpatient*** basis, for persons convalescing from ***illness*** or ***injury,*** professional nursing services, and physical restoration services to assist ***covered persons*** to

reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a registered nurse.

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

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

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

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

6. It is approved and licensed by ***Medicare.***

This term shall also apply to expenses ***incurred*** in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

Facility

A healthcare institution which meets all applicable state or local licensure requirements, such as a freestanding dialysis ***facility,*** a lithotriptor center or an outpatient imaging center.

Full-time

Employee's regularly scheduled work not less than thirty-five (35) hours per work week.

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

Home Health Aide Services

Those services which may be provided by a person, other than a Registered Nurse, which are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.

2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered Nurse. It must provide for full-time supervision of such services by a ***physician*** or Registered Nurse.

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

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under ***Medicare.***

Hospice

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.

2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.

3. It is under the direct supervision of a ***physician.***

4. It has a Nurse coordinator who is a Registered Nurse.

5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of ***hospice*** services.

7. It has a full-time administrator.

8. It maintains written records of services provided to the ***covered person.***

9. It is licensed, if licensing is required.

Hospital

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals.***

2. It is engaged primarily in providing medical care and treatment to ***ill*** and ***injured*** persons on an ***inpatient*** basis at the ***covered person's*** expense.

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury;*** and such treatment is provided by or under the supervision of a ***physician*** with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.

4. It qualifies as a ***hospital*** and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

5. It must be approved by ***Medicare.***

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a facility designed exclusively for rehabilitative services where the ***covered person*** received treatment as a result of an ***illness*** or ***injury.***

The term ***hospital,*** when used in conjunction with ***inpatient confinement*** for mental and nervous conditions or ***chemical dependency,*** will be deemed to include an institution which is licensed as a mental ***hospital*** or ***chemical dependency*** rehabilitation and/or detoxification ***facility*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Illness

A bodily disorder, disease, or physical sickness. ***Pregnancy*** of a covered ***employee*** or their covered spouse shall be considered an ***illness.***

Incurred or Incurred Date

With respect to a ***covered expense,*** the date the services, supplies or treatment are provided.

Injury

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound***.***

Inpatient

A ***confinement*** of a ***covered person*** in a ***hospital, hospice,*** or ***extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board.***

Intensive Care

A service which is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance which is prescribed by the attending ***physician.***

Intensive Care Unit

A separate, clearly designated service area which is maintained within a ***hospital*** solely for the provision of ***intensive care.*** It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital;***

2. Special life saving equipment which is immediately available at all times;

3. At least two beds for the accommodation of the critically ill; and

4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room.

Layoff

A period of time during which the ***employee,*** at the ***employer's*** request, does not work for the ***employer,*** but which is of a stated or limited duration and after which time the ***employee*** is expected to return to ***full-time,*** active work. Layoffs will otherwise be in accordance with the ***employer's*** standard personnel practices and policies.

Leave of Absence

A period of time during which the ***employee*** does not work, but which is of stated duration after which time the ***employee*** is expected to return to active work***.***

Maximum Benefit

Any one of the following, or any combination of the following:

1. The maximum amount paid by this ***Plan*** for any one ***covered person*** for a particular ***covered expense.*** The maximum amount can be for:

    a. The entire time the ***covered person*** is covered under this ***Plan,*** or
    b. A specified period of time, such as a calendar year.

2. The maximum number the ***Plan*** acknowledges as a ***covered expense.*** The maximum number relates to the number of:

    a. Treatments during a specified period of time, or
    b. Days of ***confinement,*** or
    c. Visits by a ***home health care agency.***

Medically Necessary (Medical Necessity)

Service, supply or treatment which, as determined by the ***claims processor,*** Named Fiduciary, ***employer/Plan administrator*** or their designee, to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered;

2. Supplied or performed in accordance with current standards of good medical practice within the United States***;*** and

3. Not primarily for the convenience of the ***covered person*** or the ***covered person's*** family or ***professional provider;*** and

4. Is an appropriate supply or level of service that safely can be provided; and

5. It is recommended or approved by the attending ***professional provider.***

The fact that a ***professional provider*** may prescribe, order, recommend, perform, or approve a service, supply or treatment does not, in and of itself, make the service, supply, or treatment ***medically necessary.*** In making the determination of whether a service or supply was ***medically necessary,*** the ***claims processor, employer/Plan administrator***, or its designee, may request and rely upon the opinion of a ***physician*** or ***physicians.*** The determination of the ***claims processor, employer/Plan administrator*** or its designee shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; Part C, Miscellaneous provisions regarding all programs; and Part D, Prescription Drug Benefits; and including any subsequent changes or additions to those programs.

Mental and Nervous Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Negotiated Rate

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan.***

Nonparticipating Pharmacy

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a ***participating pharmacy.***

Nonpreferred Provider

A ***physician, hospital,*** or other health care provider which does not have an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

Nurse

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) who is practicing within the scope of the license.

Outpatient

A ***covered person*** shall be considered to be an ***outpatient*** if he is treated at:

1. A ***hospital*** as other than an ***inpatient;***

2. A ***physician's*** office, laboratory or x-ray ***facility;*** or

3. An ***ambulatory surgical facility;*** and

The stay is less than twenty-three (23) consecutive hours.

Partial Confinement

A period of less than twenty-four (24) hours of active treatment in a ***facility*** licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services;

2. Treatment of ***mental and nervous disorders.***

3. Alcoholism treatment;

4. ***Chemical dependency*** treatment;

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs which is contracted within the ***pharmacy organization.***

Pharmacy Organization

The ***Pharmacy Organization*** is Data Rx.

Physician

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is practicing within the scope of his license.

Placed For Adoption

The date the ***employee*** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"Plan" refers to the benefits and provisions for payment of same as described herein.

Plan Administrator

The ***Plan administrator*** is responsible for the day-to-day functions and management of the ***Plan.*** The ***Plan administrator*** is the ***employer.***

Post-service Claim

Post-service claims are those for which services have already been received (any claims other than ***pre-service claims*****).**

Pre-existing Conditions

An ***illness*** or ***injury*** which existed within six (6) months before the ***covered person's*** enrollment date for coverage under this ***Plan.*** An ***illness*** or ***injury*** is considered to have existed when the ***covered person:***

1. Sought or received professional advice for that ***illness*** or ***injury,*** or

2. Received medical care or treatment for that ***illness*** or ***injury,*** or

3. Received medical supplies, drugs, or medicines for that ***illness*** or ***injury.***

Preferred Provider

A ***physician, hospital*** or other health care ***facility*** who has an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered. ***Preferred providers*** agree to accept the ***negotiated rate*** as payment in full.

Preferred Provider Organization

An organization who selects and contracts with certain ***hospitals, physicians,*** and other health care providers to provide ***covered persons*** services, supplies and treatment at a ***negotiated rate.*** The ***Preferred Provider Organization*** is Stratose.

Pregnancy

The physical state which results in childbirth or miscarriage.

Pre-service Claim

A ***pre-service claim*** is a claim for services for which preapproval must be received before services are rendered in order for benefits to be payable under this ***Plan***, such as those services listed in the section *Utilization Review*. A ***pre-service claim*** is considered to be filed whenever the initial contact or call is made by the ***covered person,*** provider or ***authorized representative*** to the ***Utilization Review Organization,*** as specified in *Utilization Review.*

Professional Provider

A person or other entity licensed where required and performing services within the scope of such license. The covered ***professional providers*** include, but are not limited to:

Audiologist

Certified Addictions Counselor

Certified Registered Nurse Anesthetist

Certified Registered Nurse Practitioner

Chiropractor

Clinical Laboratory

Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)

Dentist

Dietician

Dispensing optician

Nurse (R.N., L.P.N., L.V.N.)

Occupational Therapist

Optician

Optometrist

Physical Therapist

Physician

Physician's Assistant

Podiatrist

Psychologist

Respiratory Therapist

Speech Therapist

Retrospective Review

A review by the ***Utilization Review Organization*** after the ***covered person's*** discharge from ***hospital confinement*** to determine if, and to what extent, ***inpatient*** care was ***medically necessary.***

Room and Board

Room and linen service, dietary service, including meals, ***medically necessary*** special diets and nourishments, and general nursing service. ***Room and board*** does not include personal items.

Semiprivate

The daily ***room and board*** charge which a ***facility*** applies to the greatest number of beds in it's ***semiprivate*** rooms containing two (2) or more beds.

Total Disability or Totally Disabled

The ***employee*** is prevented from engaging in his regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a ***dependent*** is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.

Treatment Center

1. An institution which does not qualify as a ***hospital,*** but which does provide a program of effective medical and therapeutic treatment for ***chemical dependency*** or ***mental and nervous disorders,*** and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:

    a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
    b. It provides a program of treatment approved by the ***physician.***
    c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person.***
    d. It provides at least the following basic services:
        (1) ***Room and board***
        (2) Evaluation and diagnosis
        (3) Counseling
        (4) Referral and orientation to specialized community resources.

Utilization Review

A process of evaluating if services, supplies or treatment are ***medically necessary*** to help ensure cost-effective care.

Utilization Review Organization

The individual or organization designated by the ***employer*** for the process of evaluating whether the service, supply, or treatment is ***medically necessary.*** The ***Utilization Review Organization*** is Clinix.

Well Child Care

Preventive care rendered to ***dependent*** children.