Dublin, Vidalia, Savannah Area
EMPLOYEE HEALTH CARE PLAN
AND
SUMMARY PLAN DESCRIPTION

Revised January 1, 2022

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Introduction

This Employer has retained the services of an independent Third-Party Administrator, Core Administrative Services, Inc. (CAS), experienced in claims processing to handle claims.

The Plan Sponsor assumes the sole responsibility for funding the Employee benefits out of general assets. The Plan is intended to comply and be governed by the "Employee Retirement Income Security Act of 1974" as amended (ERISA) and not state law. Therefore, state law governing guarantee funds may not cover benefits payable under the Plan if the Plan Sponsor is unable to pay benefits. The Plan Sponsor has purchased excess risk insurance coverage which is intended to reimburse the Plan Sponsor for certain losses incurred and paid under the Plan by the Plan Sponsor. The excess risk insurance coverage is not a part of the plan.

This booklet, the Group Provisions Pages, and any amendments constitute the Plan Document for the Employer's benefit plan. this Plan is maintained for the exclusive benefit of the Employees and each Employee's rights under this Plan are legally enforceable. The Employer has the right to amend the Plan at any time and will make a "good faith" effort to communicate to you all such changes, which affect benefit payment. Amendments or modifications which affect you will be communicated to you within sixty (60) days of the effective date of a modification or amendment. Requests for exceptions to the Plan must be submitted in writing to the Plan Administrator prior to receiving the service and/or supply.

The following pages of this booklet include: the requirements for being covered under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including any limitations and exclusions), and the procedures to be followed in presenting claims for benefits and the appeal process for any claim that may have been denied.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

The Plan Administrator has the discretionary authority to decide whether a charge is Reasonable. Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Some of the terms used in the booklet begin with a capital letter. These terms have a special meaning under the Plan and they are listed in the Plan Payment Provision or Definitions section. When reading the provisions of the Plan, it may be helpful to refer to these sections. Becoming familiar with the terms defined there will give you a better understanding of the procedures and benefits described. Benefits are not contractually guaranteed.

You are entitled to this coverage if you are eligible in accordance with the provisions in this booklet. This booklet

is void if you have ceased to be entitled to coverage. No clerical error will invalidate your coverage if otherwise validly in force, nor continue coverage otherwise validly terminated.

If a clerical error occurs, the Employer reserves the right to make any corresponding contribution adjustment which will be computed on the basis of the contribution level then in effect. If you have any questions concerning your eligibility or benefits, please contact:

Core Administrative Services, Inc.
PO Box 90
Macon, GA 31202

478-741-3521
888-741-CORE (2673)

Comprehensive Major Medical Expense Benefit

The Comprehensive Major Medical Expense Benefit provides coverage for a wide range of services called covered expenses. The services associated with this benefit are covered to the extent that they are:

1. Medically Necessary;
2. Prescribed by or given by a Physician;
3. Reasonable Charges (when no Network is in place, or services are rendered Out-of-Network);
4. Provided for care and treatment of a covered Illness or Injury.

Benefits are payable in accordance with any applicable deductible amounts and benefits percentages listed in the Medical Schedule of Benefits or Plan Payment Provisions.

Plan Payment Provisions – Medical

This Plan will pay the percentages shown in the Medical Schedule of Benefits for eligible expenses, based on negotiated fees for in-network services or Reasonable Charges for services rendered out-of-network or when no network is in place, once the deductible has been met, unless otherwise indicated in the schedule of benefits.

Abortion

Elective

This is NOT a covered expense under this Plan.

Voluntary termination of pregnancy due to any reason other than endangering the life of the mother. However, if complications arise after the performance of an elective abortion, any eligible expenses incurred to treat those complications will be considered.

Medically Necessary

This is a covered expense under this Plan.

Voluntary termination of pregnancy when carrying the fetus to full term would seriously endanger the life of the mother.

Accident Expense

This is a covered expense under this Program.

Acupuncture

This is NOT a covered expense under this Plan.

Procedure involving the use of long, fine needles to puncture the surface of the body.

Alcoholism

See *Chemical Dependency / Alcoholism*.

Allergy Conditions

This is a covered expense under this Plan.

Allergy services, shots, serum, and testing.

Ambulance, Air

This is a covered expense under this Plan. The cap limits of allowable charges under this plan are set by a reasonable fee determined by Core Management Resource.

Transportation of the patient to a treatment facility by means of licensed air transportation when an alternative form of transportation would seriously threaten the condition or life of the patient. If the first facility cannot provide the necessary services, the hospital that the patient is being transferred to must be the nearest hospital that can provide services unless otherwise determined by Plan Administrator.

Ambulance, Ground

This is a covered expense under this Plan.

Emergency transportation by local, licensed professional, ground ambulance service to the nearest Hospital facility equipped to treat the emergency or to transport from one facility to another, if necessary, services are not available at the first facility.

Ambulatory Surgical Facility

This is a covered expense under this Plan.

Services of an Ambulatory Surgical Facility, only when an operative or cutting procedure is actually accomplished and cannot be performed in a Physician's office.

Anesthesia Services

This is a covered expense under this Plan.

Anesthetics and their professional administration when ordered by the Attending Physician in connection with a Covered Procedure.

Anorexia

This is a covered expense under this Plan.

An eating disorder manifested by an extreme fear of becoming obese and an aversion to food.

Artificial Insemination

This is NOT a covered expense under this Plan.

Any means of Artificial Insemination, the treatment of sexual dysfunctions not related to organic disease, or treatment relating to the inability to conceive.

Assault or Illegal Occupation

This is NOT a covered expense under this Plan.

Charges related to treatment received as a result of and while committing or attempting to commit an assault or felony, or injuries sustained while engaged in an illegal occupation.

See also General Limitations and Exclusions – Medical.

Assistant Surgeon

The charges for services of an assistant surgeon and/or licensed surgical assistant when such a Provider is required to render technical assistance at an operation. The Covered Expense for such services shall be limited to 25% of the allowable surgical fee.

Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD)

This is a covered expense under this Plan.

The charges for the diagnosis and treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder(ADHD) with the exclusion of charges for education and training.

Audiologist

The charges of an Audiologist under direct supervision of a Physician for treatment of a hearing loss or an impaired hearing function.

Behavioral Modification

See specific treatment, therapy or program.

Birth Control, Prescriptions

See *Prescription Drug Coverage*.

Birth Control, Procedure

This is a covered expense under this Plan.

Any device or procedure that requires a prescription or fitting by a Physician.

See also *Prescription Drug Coverage* and *Sterilization*.

Blood and Blood Derivatives

This is a covered expense under this Plan.

Blood transfusion services, including the cost of blood and blood plasma and other blood products not donated or replaced by a blood bank or otherwise, as well as the costs associated with autologous blood transfusions.

Bulimia

This is a covered expense under this Plan.

An eating disorder involving repeated and secretive episodic bouts of binge eating followed by self-induced vomiting, use of laxatives or diuretics, or fasting.

Calendar Year Deductible

The Calendar Year Deductible is satisfied using covered expenses incurred within the Calendar Year. The Calendar Year Deductible must be satisfied before the applicable Coinsurance will be applied. See Medical Schedule of Benefits for applicable deductible amounts.

Calendar Year Maximum Benefit

Unlimited per calendar year.

Calendar Year Out-of-Pocket Maximum

A maximum amount established by this Plan that a Covered Person pays out of his or her personal funds for any Eligible (Reasonable) Charges during any Calendar Year. Once this maximum amount is reached, this Plan will pay 100% for any additional Eligible Charges during that Calendar Year.

Note: Benefits for some Covered Services are never paid at 100%. For limitations, see specific Plan Payment Provision.

Cataract Surgery, Eye Wear Afterwards

This is a covered expense under this Plan.

Initial purchase of contact lenses or eyeglasses (but not both) if required as a result of cataract surgery.

Chemical Dependency / Alcoholism

This is a covered expense under this Plan.

For the purposes of this Plan, Chemical Dependency / Alcoholism treatment means the use of any or all of the following therapeutic techniques, as used in a treatment plan for individuals physiologically dependent upon or abusing alcohol or drugs:

1. Medication;
2. Counseling;
3. Detoxification services; or
4. Other ancillary services; such as a medical testing, diagnostic evaluation, and referral to other

services identified in a treatment plan.

Treatment of Chemical Dependency / Alcoholism on an inpatient or outpatient basis, provided such treatment is diagnosed and ordered by a licensed Physician and, only if such treatment is rendered by:

1. A licensed Hospital;
2. A state approved facility for the treatment of Mental / Nervous Conditions including Chemical Dependency / Alcoholism, operated by or under contract with the local health department;
3. A licensed consulting Psychologist;
4. A licensed professional counselor;
5. A licensed Psychiatrist; or
6. A licensed Physician.

Chemotherapy

This is a covered expense under this Plan.

Treatment of disease by means of chemical substances or drugs.

See also *Prescription Drug Coverage*.

Chiropractic Care

This is a covered expense under this Plan.

The services of a licensed Chiropractor (D.C.) in which payment would be made to a Physician providing the same services. The treatment must be:

1. Medically necessary and indicated for the diagnosis;
2. Rehabilitative, as opposed to preventive in nature; and
3. Consistent with the diagnosis for the frequency and/or duration of the services provided.

Circumcision, Penal

Adult

Routine procedures are NOT a covered expense under this Plan.

Operation to remove part or the entire foreskin on the penis.

Procedures performed due to a medical condition require pre-treatment review to determine if coverage will be available.

Newborn

This is a covered expense under this Plan.

Operation to remove part or the entire foreskin of the penis.

Clinical Trials

This is a covered expense under this Plan.

The Patient Protection and Affordable Care Act (PPACA), and which applies for plan or policy years beginning on or after January 1, 2014, group health plans must provide coverage to a "qualified individual," then such plan:

- may not deny the individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition

- may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial
- may not discriminate against the individual on the basis of the individual's participation in such trial

A "qualified individual" is a participant or beneficiary in a group health plan who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either (i) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate, or (ii) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

An "approved clinical trial" means a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either (i) a federally funded or approved study or investigation, (ii) a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a study or investigation that is a drug trial exempt from having such an investigational new drug application.

The Group Health plan requires a “qualified individual” to use an in-network provider for the approved clinical trial. The in-network provider must be an “approved trial participant” and will accept the “qualified individual”. If the “qualified individual” uses an out-of-network provider, such benefits are covered if they are part of the patient’s coverage or plan.

Finally, "routine patient costs" include all items and services consistent with the coverage provided in the plan that are typically covered for a qualified individual who is not enrolled in a clinical trial. However, routine patient costs do not include (i) the investigational item, device or service itself, (ii) items and services that are provided solely to satisfy data collection and analysis needs, and that are not used in the direct clinical management of the patient, or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. Therefore, the PPACA does not require group health plans to cover the costs of the approved clinical trial itself, but rather just the routine patient costs (e.g., laboratory services) associated with the clinical trial.

Coinsurance

Coinsurance is the percent that the Plan pays for a covered expense after any applicable Deductible has been satisfied.

Continuity of Care

If a Covered Person is receiving treatment, services or supplies from a Preferred Physician and that Preferred Physician terminates or is terminated from the Preferred Physician Network or if the Plan Administrator changes PPO Networks, benefits for such services, treatment or supplies will continue to be paid at the Preferred Physician benefit level for a period of ninety (90) days from the date of the Preferred Physician’stermination if the treatment, services or supplies are being provided for special circumstances such as:

- An acute condition;
- A life-threatening Illness; or

- Past the twenty-fourth (24th) week of Pregnancy and the Covered Person is receiving treatment inaccordance with the dictates of medical prudence.

Special circumstances mean a condition such that the treating Physician or health care Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to the patient. Special circumstances shall be identified by the treating Physician or health care Provider who must request the Covered Person be permitted to continue treatment under the Physician's or Provider's care and agree not to seek payment from the patient of any amount for which the Covered Person would not be responsible if thePhysician or health care Provider were still part of the Preferred Provider Organization (PPO) Network.

Copayment

The specific amount that a Covered Person pays for certain services, procedures or prescriptions. See the treatment, therapy, or program for applicable copayments.

Convalescent Care / Skilled Nursing Facility

This is a covered expense under this Plan. Maximum thirty (60) days per Calendar Year. (Additional days must be approved by the Medical Director prior to the 60 days expires.)

Confinement in a legally qualified Convalescent Care Facility; provided such confinement:

1. Is prescribed by a Physician who remains in attendance at least once every seven (7) days;
2. Is for necessary recuperative care of the same condition requiring the prior hospitalization;
3. Provides Skilled Nursing care or Physical Restorative services or both from an Injury or disease, and it is expected that the care received will improve the patient's condition.

The total of all necessary services and supplies (including room and board) furnished by the facility cannot exceed the daily allowance and maximum number.

Cosmetic Expenses

In most cases, this is NOT a covered expense under this Plan. If approved, claims will be reimbursed at the applicable coinsurance percentage.

This Plan requires Notification on all cosmetic expenses. Procedures or services are only covered to the extent that they result in the improvement of a bodily function.

See also *Reconstructive Surgery* and *Limitations & Exclusions section*.

Custodial Care

This is NOT a covered expense under this Plan.

Services which are custodial in nature or primarily consist of bathing, dressing, toileting, feeding, home-making, moving the patient, giving medication or acting as a companion or sitter. Custodial care does not require the continued assessment, observation, evaluation, or management by licensed medical personnel.

Deductible – Medical

See *Calendar Year Deductible*.

Deductible Carry-Over Benefit

There is no Deductible carryover from one Calendar Year to the next for Covered Charges incurred and applied to theDeductible in the last three (3) months of a Calendar Year.

Dental Care

This is a covered expense under this Plan.

Under this medical plan, dental care and treatment will be eligible only for:

1. Services necessitated as the direct result of an accidental Injury to sound natural teeth and jaw;
2. The removal of tumors;
3. The removal of unerupted, impacted teeth; or
4. The correction of congenital abnormalities.

Services that are preventive, basic restorative, major restorative, orthodontic, or for diagnostic care, including teeth broken while chewing, are not included under this medical plan except for Dental Care for dependent Children, see Dental Care Section.

See also Oral Surgery and Dental Care.

Diagnostic Services

This is a covered expense under this Plan.

Diagnostic x-ray and laboratory examinations: services of a professional radiologist or pathologist.

Drugs – Prescription

See *Prescription Drug Coverage*.

Durable Medical Equipment

This is a covered expense under this Plan.

Precertification REQUIRED if over $500.

Rental, not to exceed the purchase price (or less costly, purchase) of a Hospital bed, wheelchair, and similar Medically Necessary Durable Medical Equipment when prescribed by a licensed Physician. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase but only if prior approval is obtained from the Plan Administrator.

Eating Disorders

See *Anorexia, Bulimia, Obesity*.

Educational Services

Testing as described below is NOT covered under this Plan.

Testing in connection with learning disorders or attention deficit disorders, etc.

Educational Services, Diabetes

This is a covered expense under this Plan.

Up to three (3), one-hour sessions will be covered at 100%.

Nutritional counseling, self-care training, and/or certified diabetic education classes provided by a

Registered Nurse, Registered Dietician, Physician or Pharmacist for any diagnosis of diabetes. All initial educational services must be provided by a Certified Diabetes Educator.

Emergency Room Services

This is a covered expense under this Plan.

Treatment for services rendered in a Hospital Emergency Room.

See Schedule of Benefits for applicable deductible, copayment (per visit) and coinsurance for both In-Network and Out-of-Network facilities. Copayment is waived if admitted within twenty-four (24) hours.

Non-Accident, Non-Emergency related expenses are not covered.

See also *Urgent Care Facility* under Plan Payment Provisions section.

Employment Related Injury or Illness

This is NOT a covered expense under this Plan.

Charges for or in connection with an Injury or Illness which arise out of or in the course of any employment for wage or profit, or for which the individual is entitled to benefits under Workers' Compensation Law, Occupational Disease Law or similar legislation.

Excess of Reasonable Charges

This Plan uses a variety of data sources to determine Reasonable Charges.

Charges in excess of the Reasonable Charges for Covered procedures rendered by any non-network providers are not covered.

Excess of the Benefits Specified in this Plan

Charges not covered, or charges for Benefits not covered under this Plan.

Experimental or Investigational Services or Supplies

This is NOT a covered expense under this Plan.

Except as covered under "Clinical Trials", charges incurred for services, supplies, devices, treatments, procedures and drugs which are not reasonable and necessary or that are investigational or experimental for the diagnosis or treatment of any illness, disease, or injury for which any of such items are prescribed.

Experimental or Investigational services are further defined as those services which:

1. cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has been granted; or
2. are subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or
3. are not accepted as standard medical treatment for the illness, disease or injury being treated by a Physician's suitable medical specialty; or
4. are subject to approval or review of an Institutional Review Board (IRB) of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of services, including without limitation, the Federal Department of Health and Human Services, Food and Drug Administration, or any comparable state governmental agency, and The Centers for Medicare and

Medicaid Services (formerly HCFA) as approved for reimbursement under Medicare Title XVIII; or
5. are performed subject to the Covered Person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment

In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively:

1. the member's medical records,
2. the written protocol(s) or other documents(s) pursuant to which the service has been or will be provided,
3. any consent document(s) the member or member's representative has executed or will be asked to execute, to receive the service,
4. the files and records of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
5. the published authoritative medical or scientific literature regarding the service, as applied to the member's illness or injury, and
6. regulations, records, applications, and any other documents or actions issued by, filed with, or taken by the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions

Family Provided Services

This is NOT a covered expense under this Plan.

Charges for services or supplies rendered by the Employee, Employee's Spouse, or the Children, Brothers, Sisters, Parents, or Grandparents of either the Employee or the Employee's Spouse.

Flu Shots

This is a covered expense under this Plan.

Influenza vaccine administered by the Health Department or any other licensed provider or facility.

Foreign Assignments

When temporarily assigned outside the United States of America, Medically Necessary Charges and Services, rendered by a licensed Physician or facility, incurred in a foreign country will be covered the same as if they had been incurred within the United States subject to all other provisions of this Plan.

Foreign Travel/Travel Outside the United States.

Charges incurred as the result of travel outside the United States or its territories specifically for the purpose of receiving medical treatment are NOT covered expenses under this Plan.

The charges for medical services incurred while traveling outside the United States and its territories ARE a covered expense provided that:

1. Treatment is a result of a Medical Emergency, and services are Medically Necessary and recognized as usual treatment for that condition;

2. Medical expenses are considered Reasonable and Usual and Customary based on the nearest U.S.

geographic location to point of service;
3. Procedures are approved by the AMA;
4. All usual Plan provisions, Maximum Benefits, exclusions, and limitations apply;
5. Expenses must be filed in U.S. dollar amounts;
6. Services must be translated into English; and
7. Benefits may not be assigned to a Provider.

Gastric Bypass

This is NOT a covered expense under this Plan.

Any charges leading to or in connection, such as removal or complications with Gastric Bypass will not be covered.

Genetic Testing

A genetic test examines the genetic information contained inside a person's cells, called DNA, to determine if that person has or will develop a certain disease or could pass a disease to their offspring.

1. Testing MUST be notified to Core Health Services (CHS). Genetic Testing requirements are:
    a. The beneficiary MUST have a history of the disease, breast cancer at the age of 45 or younger.
    b. There MUST be a high-risk family history.
    c. Pre-testing genetic counseling MUST be provided by a qualified genetic counselor. There MUST be an informed consent signed by the patient which includes a statement that he/she agrees to post-testing counseling. THIS IS REQUIRED.
2. The results of the testing MUST be used to manage the course of treatment of the patient's disease process.

Genetic Testing is not covered for routine diagnostic treatment, to rule-out pre-disposition, for prophylactic services (preventive screening).

See also Genetic Counseling.

Government Owned / Operated Facility

This is NOT a covered expense under this Plan.

Charges by a facility owned or operated by the U.S. Federal, State or Local government, unless the individual is legally obligated to pay. This does not apply to covered expenses rendered by a hospital owned or operated by the U.S. Veteran's Administration when the services are provided for a non-service-related Illness or Injury.

Hair Replacement and / or Wigs

This is NOT a covered expense under this Plan.

Care, treatment, or replacement for hair loss whether or not prescribed by a Physician including Hair Pieces and Wigs, as well as Wig Maintenance, <u>EXCEPT wigs for hair loss during chemotherapy or radiation therapy.</u>

Hearing Aids and Hearing Exams

This is NOT a covered expense under this Plan.

Charges incurred in connection with routine hearing exams and charges for the purchase or fitting of hearing aids/devices or such similar aid devices.

This exclusion does not apply to routine hearing screenings as required for Preventive Care for Children or the initial purchase of a hearing aid if the loss of hearing is a result of an Illness, Accidental Injury, Congenital Anomaly or Surgical Procedure.

Home Health Care

This is a covered expense under this Plan.

Each visit by a nurse or therapist will be considered one visit and four (4) hours of home health aide services will be considered one visit. Maximum number of visits limited to one-hundred thirty (130) per calendar year.

Please call one of the nurse case managers at Core Health Services (CHS) (478-741-3521 or 888-741-CORE) for assistance in making home health care arrangements. If there are no In-Network Home Care Agencies, there is no penalty for going Out-of-Network.

The patient should be under the direct care and supervision of a Physician and the Physician should have a written plan of treatment which should be reviewed and renewed at least every thirty (30) days. Each visit by a nurse or therapist of the home health agency shall be considered as one home health care visit. The patient should require skilled care as opposed to assistance with activities of daily living. There should also be the capacity for improvement or the need for continued care to prevent deterioration for the condition being treated.

Skilled nursing services by a state licensed home healthcare agency and delivered by one of the following health professionals would be covered:

1. Registered Nurse (RN);
2. Licensed Vocational or Practical Nurse (LVN/LPN);
3. Physical Therapist;
4. Occupational Therapist;
5. Speech Therapist; and
6. Home Health Aide in conjunction with Skilled Nursing care when rendered under the supervision of a Registered Nurse.

In addition, the following will be covered if prescribed by a Physician and to the extent such charges would have been covered under the Plan:

1. Prescribed Drugs;
2. Medical Supplies prescribed by a physician;
3. Related pharmaceutical services; and
4. Laboratory services.

Services *NOT* covered include:

1. Improvements to home such as handrails, ramps, air conditioners, telephones, whirlpool tubs, or other similar appliances and devices;
2. Food services such as "Meals on Wheels";
3. Custodial or non-medical services;
4. Social workers' services;
5. Services provided by a family member or household member;
6. Housekeeping services except by home health aides as ordered in the home health care treatment plan and in conjunction with Skilled Nursing Services;
7. Maintenance therapy;
8. Babysitting services;
9. Transportation;
10. Any period during which the patient is not under the Continuing care of a Physician or does not have an updated treatment plan;
11. Not medically necessary services; or
12. Purchase of dialysis equipment.

Hospice Care

This is a covered expense under this Plan.
If there are no In-Network Hospice Agencies, there is no penalty for going Out-of-Network.

Inpatient or outpatient hospice care is covered to the Plan maximum provided that a written plan of treatment is furnished as part of the claim submission. The Hospice plan treatment must include:

1. Description of the services and supplies for the palliative care and medically necessary treatment to be provided to the covered patient;
2. Be reviewed and approved by the Physician every sixty (60) days;
3. A prognosis that the patient is terminally ill and has only six (6) months or less to live; and
4. The concurrent opinion of the Physician and the Hospice care facility that such care will cost less total than any alternative treatment.

When furnished by a duly licensed agency, the following are covered expenses:

1. Facility charges including room and board for short term inpatient care;
2. Medical supplies, drugs and medications prescribed by a Physician which are normally covered under the Plan;
3. Intermittent nursing care;
4. Physician charges;
5. Intermittent home health-aide services (up to eight (8) hours a day);
6. Psychological counseling;
7. Physical or occupational therapy (for palliative reasons only);
8. Respite care that is continuous care in the most appropriate setting for a maximum of five days; and
9. Rental of durable medical equipment when prescribed by a Physician.
10. Bereavement counseling.

In addition to General Limitations in the Plan, benefits will *NOT* be provided for any of the following:

1. Funeral arrangements;
2. Pastoral counseling;
3. Financial counseling which includes estate planning;
4. Legal counseling which includes the drafting of a will;
5. Homemaker or caretaker services which are not solely related to the care of the patient;
6. Transportation;
7. Supportive environmental materials such as handrails, ramps, air conditioners, telephones, whirlpool tubs, and similar appliances and devices;
8. Food service programs such as "Meals on Wheels";
9. Nutritional Guidance;
10. Services of a social worker;
11. Any services or supplies not included in the plan of treatment;
12. Services performed by a family member, household member or volunteer worker;
13. Separate charges for records and reports; and
14. Expenses for the normal necessities of living, such as food, clothing, and household supplies.

Hospital Admissions

This is a covered expense under this Plan.

All Hospital Admissions must be medically necessary.

See also *Notification* and *Concurrent Review Requirements*.

Hospital Services

This is a covered expense under this Plan.

Hospital room and board, general nursing care, and regular daily services to the room and board allowance, Intensive Care Unit or other special care unit such as Coronary Care (but not for the concurrent use of any other Hospital room), Ambulatory Surgical Center or a Birthing Center. Room charges made by a Hospital having only private rooms will be paid at the average private room rate.

Medically necessary services and supplies furnished by a Hospital on an inpatient or outpatient basis, including but not limited to emergency and operating room charges, x-rays and other diagnostic procedures, laboratory tests, drugs, medicines, and dressings.

Personal comfort or incidental items such as telephones or televisions are excluded under this Plan.

See also *Notification* and *Concurrent Review Requirements*.

Immunizations

See *Routine Physical Exams* and *Well Baby Care*.

Immunizations required for foreign travel are not covered.

Incapacitated Child Provision

The child must be:

1. Unmarried and incapable of self-sustaining employment because of intellectual disability or physical disability; that existed before the child reached the limiting age;
2. Be chiefly Dependent on the Employee for support; and

3. Charges are not a covered expense under a conversion policy.

To qualify for continued coverage under the Incapacitated Child Provision, the child must meet specific requirements as defined in this Plan. The appropriate form may be obtained from the Benefits office.

KIS Imaging Radiological Benefit

KIS Imaging is a Preferred Radiology Network for MRI, CT and PET scans. The radiological services which are provided by KIS are payable as specified in the Schedule of Benefits. No Calendar Year Deductible, Copay or Coinsurance applies to Covered Charges provided by KIS Imaging.

Learning Disorders

This is NOT a covered expense under this Plan.

Testing services in connection with Learning Disorders, excluding testing for attention deficit disorder, which *IS* a covered expense.

See Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD)

Lifetime Maximum Benefit

The maximum amount The Plan will pay for non-essential covered expenses incurred during a covered participant's lifetime or by each of their Covered Dependents during the Dependent's lifetime.

Payments made for all essential benefits during the entire period of coverage for one Covered Person are not limited to the Lifetime Maximum Benefit, unless otherwise noted under a specific covered expense area.

Mammogram

This is a covered expense under this Plan.

One (1) routine mammogram procedure per calendar year. Additional Mammogram procedures will be covered only if determined to be Medically Necessary.

See also *Routine Physical Exam* for detailed coverage limits.

Mastectomy (Women's Health and Cancer Rights)

This is a covered expense under this Program.

For members receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductible and Coinsurance applicable to other medical and surgical benefits provided under this Plan.

If you would like more information on WHCRA benefits, call your Plan Administrator.

See also *Reconstructive Surgery*.

Maternity Expenses

This is a covered expense under this Plan.

The charges for maternity care, on the same basis as any Illness covered under this Plan for Covered Employees and covered Dependents. Plan coverage for a hospital stay in connection with childbirth for both the mother and the newborn Child will be no less than: forty-eight (48) hours following a normal vaginal delivery, or ninety-six (96) hours following a cesarean section, unless a shorter stay is agreed to by both the mother and her attending Physician.

In any case, this Plan may not, under federal law, require that a provider attain authorization from The Plan for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours as applicable.) However, this Plan reco **Maternity Expenses**

This is a covered expense under this Plan.

The charges for maternity care, on the same basis as any Illness covered under this Plan for Covered Employees and covered Dependents. Plan coverage for a hospital stay in connection with childbirth for both the mother and the newborn Child will be no less than: forty-eight (48) hours following a normal vaginal delivery, or ninety-six (96) hours following a cesarean section, unless a shorter stay is agreed to by both the mother and her attending Physician.

mmends Pre-Notifying CHS during the first trimester of a Maternity Diagnosis and again within forty-eight (48) hours of delivery of the baby.

For hospital stays longer than forty-eight (48) hours (or ninety-six (96) hours as applicable), Notification must be made to CHS, and will be subject to the Notification penalties as defined in *Notification Requirements*.

Includes expenses incurred for Pregnancy and Complications of Pregnancy.

Coverage includes expenses for confinements in a Birthing Center and services rendered by a Certified Nurse Midwife.

Mental / Nervous Conditions

Treatment of Mental / Nervous on an inpatient or outpatient basis, provided such treatment is diagnosed and ordered by a licensed Physician and, only if such treatment is rendered by:

1. A licensed Hospital;
2. A state approved facility for the treatment of Mental / Nervous Conditions including Chemical Dependency / Alcoholism, operated by or under contract with the local health department;
3. A licensed consulting Psychologist;
4. A licensed professional counselor;
5. A licensed Psychiatrist;
6. A licensed Physician;
7. A licensed Clinical Social Worker; or
8. A licensed Marriage & Family Therapist.

In addition to General Limitations of this Plan, benefits will NOT be provided for any of the following:

1. Services rendered by any other providers, i.e., Psychiatric Nurse Practitioners, Counselors, or Therapists when such services are billed independently and not through a Covered Facility; and
2. Marriage and Family Counseling, unless all parties involved have a diagnosed Illness or injury. If one family member has a covered diagnosed condition, benefits will be prorated for the diagnosed Covered Person (individual) only.

NETWORK

See Preferred Provider Information Section.

Newborn Expenses

This is a covered expense under this Plan.

Newborn expenses (all physician and facility fees), from birth until discharge for routine care, will be paid provided coverage is requested within thirty-one (31) days of the child's birth. (Enrollment card must be submitted within thirty-one (31) days of the date of child's birth.) These expenses will be paid under the mother.

If the baby is ill, suffers an injury, or requires care other than routine care, from birth until discharge, benefits will be provided on the same basis as for any other eligible expenses provided coverage is in effect. These expenses will be paid under the Newborn.

See also *Well Baby Care*.

No Legal Obligation to Pay

This is NOT a covered expense under this Plan.

Charges by a Physician, facility or other provider in which the individual is not legally obligated to pay.

Not Medically Necessary

This is NOT a covered expense under this Plan.

Treatment of an Injury or Illness which is not Medically Necessary. This includes charges for care, supplies or equipment.

Obesity or Weight Control

This is NOT a covered expense under this Plan.

Treatment, supplies, medication or surgery primarily intended for weight loss or any complications that occur as the result of any of the above services.

See also *Preventive Care*

Oral Surgery

This is a covered expense under this Plan.

Notification is required. To obtain the highest level of benefits, the member must Notify CHS within 48 (forty-eight) hours after the date of service.

Covered Services include only the following:

- Fracture of facial bones;
- Lesions of the mouth, lip or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;

- Dislocations of the jaw;
- Removal of impacted teeth and associated hospitalization. Notification must be made to CHS.
- Treatment of Temporomandibular Joint Syndrome (TMJ) or myofascial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered services do not include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures);
- Plastic repair of the mouth or lip necessary to correct traumatic injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily injury to sound natural teeth or structure.

See also Dental Care.

Osteoporosis

This is a covered expense under this Plan.

Benefits will be provided for qualified individuals for reimbursement for scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis and treatment of osteoporosis for Members meeting USPSTFB B criteria. For more information, visit: http://www.uspreventiveservicestaskforce.org/

Out-of-Pocket Limit

See *Calendar Year Out of Pocket Maximum*.

Oxygen

This is a covered expense under this Plan.

If there are no In-Network Providers, there is no penalty for going Out-of-Network.

Oxygen and its administration when prescribed by a licensed Physician.

Pap Smears

This is a covered expense under this Plan.

See *Routine Physical Exams*.

Personal Hygiene

This is NOT a covered expense under this Plan.

Items for personal hygiene and convenience which are Not Medically Necessary, such as, but not limited to, air conditioners, bathing / toilet accessories, and physical fitness equipment.

Physician / Specialist Copayment

The Physician/Specialist copayment is listed in the Schedule of Benefits for each Plan per In-Network office visit, not per service.

A copayment is a flat amount that a Covered Person pays at the time of the office visit. After the copayment, the appropriate coinsurance will be applied. After the Calendar Year Out-of-Pocket Maximum has been reached, the copayment amount will not apply.

Physician Charges, Certain

This is NOT a covered expense under this Plan.

Failure to keep scheduled appointments, completion of claim forms or providing medical information necessary to determine coverage.

Physician Charges, Telehealth. The law defines Telemedicine services as, "The practice, by a duly licensed physician or other health care provider acting within the scope of such provider's practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient, or which are used to transfer medical data obtained during a medical visit with a patient."

Pre-Admission Testing

This is a covered expense under this Plan.

Pre-Admission Testing performed within ten (10) days of admission.

Pre-Existing Conditions

This Plan does not impose a pre-existing condition limitation. That means that if an individual or their Dependents have a pre-existing condition when enrolling in The Plan, all eligible services related to the pre-existing condition will be covered without restriction, assuming the condition itself is covered.

Preferred Provider Information

The Preferred Provider Network (PPO) does **not** include services and supplies provided by Hospital Facilities, Ambulatory Surgery Center Facilities and by dialysis clinics or Facilities except for the Facilities identified in the Schedule of Benefits as Level IA Facilities. For these types of Providers, and for all Non-PPO Providers, the Plan will identify the Reasonable cost for the services and supplies through its Claim Reviewand Audit Program. There is a section in this Summary Plan Description that fully describes the Claim Review and Audit Program, and the benefits for these Providers are described separately in Level I of the Schedule of Benefits. You may also contact the Claims Administrator or the Plan Administrator with any questions regarding which Facilities may be included under the Claim Review and Audit Program, and which may be included under the PPO network agreement.

For Physicians and all other Providers of service, this Plan contains provisions under which a Plan Participant may receive more benefits by using certain Providers. There is a section in the Schedule of Benefits which describes the benefits for PPO and Non-PPO Providers (Level II). PPO Providers are individuals and entities that have contracted with the Plan to provide services to Plan Participants at pre- negotiated rates. A list of these Preferred Providers can be accessed on the PPO website free of charge. In addition, a Plan Participant may request a Preferred Provider list by contacting the Plan Administrator. The Preferred Provider list changes frequently; therefore, it is recommended that a Plan Participant verify with the Provider that the Provider is still a Preferred Provider before receiving services. Please refer to the Plan Participant identification card for the PPO website address.

This Plan may use Allowable Claim Limits to determine Covered Charges in lieu of a PPO discount.

Pre-Marital Exams

This is NOT a covered expense under This Plan.

Blood testing for the purpose of obtaining a Marriage License.

Preventive Care

As required by the Patient Protection Affordable Care Act (PPACA), Covered Participants are not responsible for paying for eligible preventive care services received from an in-network/participating provider. These eligible preventive care services will be paid by The Plan at 100%, no deductible. Such services include:

- Evidence-based recommended items or services of the United States Preventive Services Task Force (USPSTF) with a rating of "A" or "B";
- Immunizations recommended from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC); and
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, adolescents and women.

Note: Recommended ages and populations vary for the services listed above. In addition, eligible preventive care services received from an out-of-network/non-participating provider will not be covered.

Providers are legally required to code and bill accurately for services they provide to patients. Covered services are paid based on the billing codes used by the Covered Participant's provider on the claim submitted to the medical Claims Administrator for payment. Therefore, the Covered Participants may be responsible for a portion of the preventive care visit when:

- the service is not billed as preventive care (including those that may have been received at the same time as the Covered Participant's preventive care visit);
- the Covered Participant does not meet the criteria (based on age or population) for the recommendation or guideline for the preventive care service; or
- the preventive care service was received from an out-of-network/non-participating provider.

<u>Covered Preventive Services for Adults</u>

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 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
- Falls prevention in older adults: exercise or physical therapy
- Falls prevention in older adults: vitamin D
- Diet counseling for adults at higher risk for chronic disease
- Hepatitis B screening for non-pregnant adolescents and adults
- Hepatitis C virus infection screening: adults
- HIV screening for all adults at higher risk

- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
- Intimate partner violence screening; women of childbearing age
- Lung cancer screening for adults 55- 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
- Obesity screening and counseling for all adults
- Physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors
- Preeclampsia prevention: aspirin
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Skin cancer behavioral counseling
- Syphilis screening for all adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users

<u>Covered Preventive Services for Women, Including Pregnant Women</u>

- 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 1 to 2 years for women over forty (40)
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breast Feeding interventions to support and promote breast feeding. This includes breast pumps.
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, patient education and counseling, not including abortifacient drugs
- 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 to 28 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 cytology results who are 30 or older

- Osteoporosis screening for women over age sixty (60) depending on risk factors and in younger women whose fracture risk is equal to or greater than that of a sixty (60) year old women who has no additional 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
- Syphilis screening for all pregnant women or other women at increased risk
- Well-woman visits to obtain recommended preventive services

Covered Preventive Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at eighteen (18) and twenty-four (24) months
- Behavioral assessments for children of all ages
- Blood Pressure screening for children
- 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
- 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:
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus influenzae type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus
    - Inactivated Poliovirus
    - Influenza
    - 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 higher risk
- Tobacco use interventions: children and adolescents
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children

For detailed information on these preventive services, contact your Claims Administrator or go to https://www.healthcare.gov/coverage/preventive-care-benefits/ .

Prophylactic Services

This is not a covered expense under this Plan.

An institution of measures to protect the member from a disease to which he or she has been, or may be, exposed. Also called preventive treatment.

For the purposes of this Plan, prophylactic or preventive services includes (but is not limited to) surgery, facility charges, prescription drugs, and/or testing.

See also *Genetic Testing*.

Prostate Exams

This is a covered expense under this Plan.

See *Routine Physical Exam for Coverage*.

Prosthetics/Orthotics

This is a covered expense under this Plan.

Artificial limbs and eyes (standard prosthetic devices only), arm braces, leg braces (and attached shoes), custom molded shoe inserts, when necessitated as the result of a physical illness or injury, including prosthetic devices following a covered mastectomy. Penile Prosthesis must be medically necessary.

Charges for replacements will be covered only when required because of pathological change or the natural growth process. Charges for the repair and maintenance are not included; Maintenance contracts are subject to approval by Core Health Services.

Radiation

This is a covered expense under this Plan.

Medically Necessary treatment of disease by Radium and radioactive isotope therapy.

Reconstructive Surgery

This is a covered expense under this Program.

Notification is required. Reconstructive surgery does not include any service otherwise excluded in this Plan. (See Limitations & Exclusions)

Reconstructive Surgery is covered only to the extent Medically Necessary:

- To restore a function of any body area which has been altered by disease, trauma, Congenital/Development Anomalies or previous therapeutic processes;
- To correct congenital defects of a Dependent child that lead to functional impairment; and
- To correct medical complications or post-surgical deformity, unless the previous surgery was not a Covered Service.

See also *Mastectomy.*

Rehabilitation Care

Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible.

See also *Therapy.*

Robotic Assisted Surgery Policy

For the purposes of this Plan, robotic assistance is considered incidental to the primary surgical procedure. No additionally benefits are payable for the use of the robotic system. Surgical procedures completed with robotic assistance should be billed under the CPT code for the primary surgical procedure. Robotic technique should be indicated on the bill with CPT S2900, but indicated with no separate charge for the technique.

Routine Physical Exams

This is a covered expense under this Plan.

To include annual routine physical exams, pap smears, prostate screening (PSA), mammograms and any other related laboratory or x-ray expenses, when recommended by a licensed Physician.

Immunizations required for foreign travel are NOT covered.

See also *Preventive Care.*

Second Surgical Opinion

This is a covered expense under this Plan.

A second Surgical Opinion is recommended, and may be required, when any surgical procedure is to be performed on an inpatient or outpatient basis.

See also *Notification and Concurrent Review*.

Self-Inflicted Injuries

This is a covered expense under this Plan.

Charges for services or supplies furnished in connection with intentionally Self-Inflicted Injuries or suicide, whether committed while sane or insane. Also see Exclusions.

Smoking Cessation

Counseling – *This is a covered expense under this Plan.*

Medication – *See Prescription Drug Coverage.*

Any smoking cessation program, therapy, counseling or medication for the purpose of quitting smoking.

Sterilization

This is a covered expense under this Plan.

Procedures such as Vasectomies and tubal ligations.

Supplies, Diabetic

This is a covered expense under this Plan.

Needles, syringes, lancets, clinitest, glucose strips and chemstrips for diagnosed diabetes.

See also *Prescription Drug Coverage*.

Supplies, Medical and Surgical

This is a covered expense under this Plan.

Casts, splints, trusses, braces, crutches, surgical dressings and supplies, including ostomy supplies and similar Medically Necessary medical and surgical supplies as prescribed by a licensed Physician.

See also *Supplies, Diabetic*.

Surgery

When two or more surgical procedures occur during the same operation, the eligible expenses for all charges are as follows:

- When multiple or bilateral surgical procedures that increase the time and amount of patient care are performed, the eligible expense is the UCR fee for the major procedure plus 50% of the UCR fee for each of the lesser ones.
- When an incidental procedure is performed through the same incision, the eligible expense is the UCR fee for the major surgical procedure only. Examples of incidental procedures as excision of a scar, appendectomy, lysis of adhesions, etc.

Surgery, Assistant

This is a covered expense under this Plan.

When an assistant surgeon is required to render technical assistance on an operation, the eligible expense for such services shall be limited to 20% of the UCR charge of the surgical procedure and shall be payable subject to the deductible and to the applicable coinsurance.

Temporomandibular Joint Dysfunction

This is a Covered Service under this Plan.

See also *Oral Surgery*.

Therapy

This is a Covered Service under this Plan. Precertification required for pulmonary and speech therapy.

<u>Biofeedback, Recreational or Educational</u>

See specific treatment, therapy or program.

Occupational

This is a covered expense under this Plan.

Medically prescribed Occupational Therapy rendered by a duly qualified Occupational Therapist to improve or restore a patient's ability to perform all activities of daily living.

Physical

This is a covered expense under this Plan.

Limited to Thirty (30) visits, services must begin within three (3) days of a Covered Surgical Procedure or Covered Hospital Admission.

Medically prescribed Physical Therapy rendered by a duly qualified Physical Therapist to correct, alleviate, or limit physical disability, bodily malfunction, or pain from Injury or disease.

Pulmonary Rehabilitation

This is a covered expense under the Program.

Medically prescribed Pulmonary Rehabilitation rendered by a duly qualified Therapist to structure a program of activity, progressive breathing and conditioning exercise, and patient education designed to return patients with pulmonary disease to maximum function.

See also *Rehabilitation Care*

Speech

This is a covered expense under this Plan.

Congenital conditions or diseases causing delayed speech development in children are NOT a covered expense under this Plan.

Medically prescribed services of a legally qualified Physician or qualified Speech Therapist for respiratory or rehabilitative Speech Therapy for speech loss or impairment due to an Illness or Injury, other than a functional nervous disorder, or due to surgery because of Illness.

Transplant

See separate Organ Transplant Policy.

Transsexual Surgery

This is NOT a covered expense under this Plan.

Charges leading to or in connection with Transsexual Surgery.

See also General Limitations and Exclusions section.

Urgent Care Facility

This is a covered expense under this Plan.

Please see schedule of benefits for applicable copayment and coinsurance of the allowable charges for In-Network and Out-of-Network benefits - (Deductible does not apply)

For Accident-Related Services see also *Accident Expense*.

Services rendered at a facility described as an urgent care facility, which is not a physician's office, clinic, hospital, or ambulatory surgical facility.

Vision Expenses

This is NOT a covered expense under this Plan.

Eye refractions, eyeglasses or contact lenses to correct refractive errors and related services, including surgery performed to eliminate the need for eyeglasses for refractive errors (such as radial keratotomy). *This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act. See Vision Care.*

See also *Cataract Surgery, Eye Wear Afterwards*.

War or acts of War

This is NOT a covered expense under this Plan.

Declared or undeclared, including an Injury sustained or Illness contracted while on duty with any Military Service for any country.

Well Baby Care

This is a covered expense under this Plan.

Physician's fees for routine care, examination, or immunizations from date of hospital discharge to one year of age, see preventive care section for covered children.

For Children over one year of age, refer to Preventive Care for Children or *Routine Physical Exam.* See also *Newborn Expenses*.

General Limitations and Exclusions – Medical

No payment will be made under any portion of this Plan for expenses incurred by a Covered Person for:

1. **Allergy Services** - Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine auto injections;
2. **Beautification Procedures** – Cosmetic Surgery, reconstruction surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary by Core Management Resources, is not covered.
    a. This exclusion does not apply to surgery to restore function if any body area has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of Injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.
    b. The following criteria must be met to qualify for breast reduction surgery: the affected area must be more than 250 grams over the normative average. Breast reduction surgery must meet certain criteria for coverage including a tissue removal minimum.

   This exclusion does not apply to Breast Reconstruction Surgery. Please see Mastectomy in the Schedule of Benefits section.
3. **Before Coverage Begins** - Charges incurred prior to the date an individual becomes a Covered Person or charges incurred after the date he ceases to be a Covered Person;
4. **Care, Supplies, or Equipment** – Care, supplies, or equipment not Medically Necessary, as determined by Core, for the treatment of an injury or illness. Non-covered supplies are inclusive of but not limited to Band-Aids, tape, non-sterile gloves, thermometers, heating pads and be boards. Other non-covered items include household supplies, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, exercise and massage equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a participant's house or place of business, and adjustments made to vehicles;
5. **Complications** – Complications of non-covered procedures are not covered;
6. **Counseling** – Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy;
7. **Crime** - Charges resulting from or occurring from the commission of a crime, illegal act, felonious act, or while engaging in an illegal occupation or act, or aggravated assault by the Covered Person, including, without limitation, illegally driving by the Covered Person while under the influence of alcohol or drugs, but excluding minor traffic violations. The Plan Administrator, in its sole discretion, shall determine whether this exclusion applies—a criminal conviction is not required. (This exclusion will not apply to any other Covered Persons who may also have been injured but are not deemed to be a party-at-fault or contributor.);
8. **Dental Surgery** - Any day of Hospital confinement as an Inpatient or Outpatient unless:

a. The dental services rendered are covered services under this Plan;
b. The Covered Person has a medical condition, other than the proposed denial procedure, which;
    - exists prior to surgery, and
    - makes it medically necessary for the dental procedure to be performed in the Hospital.

8. **Dental Treatment** - except as relates to accidental injuries outlined elsewhere in this document, or if Dental Benefits are a component of this Plan;
9. **Educational for Learning Disorders** - Charges for special education and/or learning disorders; See ADD/ADHD*
10. **Experimental or Investigational Services** – Charges for treatments, procedures, equipment, drugs, devices, or supplies. This includes:
    a. care, procedure, treatment protocol or technology which:
        - is not widely accepted as safe, effective and appropriate for the injury or sickness throughout the recognized medical profession and established medical societies in the United States; or
        - is experimental, in the research or investigational stage or conducted as part of research protocol, or has not been proven by statistically significant randomized clinical trials to establish increase survival or improvement in the quality of life over other conventional therapies;
    b. drugs, test and technology which:
        - the FDA has not approved for general use;
        - are considered experimental;
        - are for investigational use; or
        - are approved for a specific medical condition but applied to another condition.

    We will rely on the Data project of the American Medical Association Health Care Financing Administration, the National Institute of Health, the U.S. Food and Drug Administration, the National Cancer Institute, Office of Heath Technology Assessment in determining investigational or experimental services. Final decision as to what constitutes an experimental or investigational service will be at the discretion of the Plan Administrator;
11. **Failure to Keep a Scheduled Visit** - Charges made by a Physician for the Covered Person's failure to appear as scheduled for an appointment; charges for filing claim forms; or utilization charges made by a provider;
12. **Foot Care** (Podiatry)– when recommended by a physician as a result of infection. The following foot charges for foot care will also be covered:
    - Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
    - Treatment of corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
13. **Free Services** - Charges that would not have been made if no coverage existed or charges that a Covered Person is not required to pay;
14. **Government Programs** - Charges incurred for services or supplies which are furnished, paid for, or otherwise provided for by reason of the past or present services of any Covered Person in the armed forces of a government;
15. **Hair Loss** – Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth; See hair loss/ Wigs
16. **Homes** – Services provided by a rest home, a home for the aged, a nursing home or any similar facility;
17. **Hypnotherapy** - therapy used to create subconscious change in a patient in the form of new responses, thoughts, attitudes, behaviors or feelings;

19. **Infertility** – Services related to or performed in conjunction with artificial insemination, in-vitro fertilization, reverse sterilization or a combination thereof;
20. **Medical and Service Errors** - The plan does not recognize the following as covered expenses.

    Treatment or services, including hospitalizations, in any way related to:

    - Surgery performed on the wrong body part;
    - Surgery performed on the wrong patient; or
    - Wrong surgery performed on a patient.

    Treatment or services which were required as a result of:

    - Administration of ABO-incompatible blood or blood products;
    - Foreign objects left in patient after surgery;
    - Decubitus ulcers acquired after admissions;
    - Facility-acquired injuries such as fractures, dislocations, burns, intracranial injuries;
    - Facility-acquired infections from vascular or urinary catheters; or
    - Medication error during Facility confinement. For purpose of this section "medication error" shall mean the wrong drug, wrong dose, wrong, patient, wrong time, wrong rate, wrong preparation or wrong route of administration.
21. **Not Medically Necessary** - Charges for services and supplies which are not medically necessary for treatment of the sickness or injury or are not recommended and approved by the attending physician;
22. **Obesity** – Any services or supplies for the treatment of obesity, including but not limited to weight reduction, medical care or Prescription Drugs, or dietary control (except as related to covered nutritional counseling) and listed under covered services. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of nutrition;
23. **Personal Comfort Items** - Charges, incurred for services or supplies, which constitute personal comfort or beautification and are chosen by the Covered Person;
24. **Physical Therapy** - Charges for physical therapy unless ordered by a Physician to restore prior function;
25. **Provider (Close Relative or Self)** - Charges for services provided by the Covered Person or the Covered Person's Spouse, child, brother, sister, or parents, whether by blood or by law;
26. **Reasonable Charges**- Any portion of an expense, charge, or fee that exceeds the Reasonable Charges as determined by Core;
27. **Sexual Modification/Dysfunction Treatments** - Charges for or related to sex change surgery (transsexualism) or any treatment related to gender identity, fertility drugs, fertility studies, sterility studies, artificial insemination, in-vitro fertilization, services of a surrogate mother, and treatment for infertility;
28. **Shoes** – Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace) (orthotics are limited to the initial pair);
29. **Speech Therapy** - Charges for speech therapy unless ordered by a physician for the restoration of speech when speech loss is due to:
    a. Cerebral Vascular Accident (stroke)
    b. Cerebral Tumor
    c. Laryngectomy
30. **Transplants** - The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:

1. Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
2. Transportation, travel or lodging expenses for non-donor family members;
3. Donation related services or supplies associated with organ acquisition and procurement;
4. Chemotherapy with autologous, allogenic or syngeneic hematopoietic stem cells transplant for treatment of any type of cancer not specially named as covered;
5. Any transplant not specially listed as covered.

31. **Transportation** – Transportation provided by other than a state licensed Professional Ambulance Service, and ambulance services other than in a Medical Emergency. Ambulance transportation from the Hospital to the home is not covered;
32. **Treatment (Outside of U.S.)** - Charges incurred outside the United States if the Covered Person traveled to such a location for the primary purpose of obtaining medical services, drugs, or supplies;
33. **Vision** – Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Eye Refraction -analysis of vision or the testing of its acuity. Services or devices to correct vision or for advice on such service, except those specifically listed as covered in this booklet;
34. **Vision (Surgical Correction)** – Radial Keratotomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem;
35. **Surgical correction** – for ineligible Charges (e.g. gastroplasty, Gastric Bypass, or non-medical treatment of obesity, (e.g. dietary or exercise counseling for weight control, etc.));
36. **War** - Charges incurred in connection with the care or treatment of any sickness contracted or injury sustained which is occupational or which results from war or any act of war, declared or undeclared;
37. **Workers' Compensation** - Charges for expenses incurred for any condition for which a Covered Person is eligible for coverage or benefits under Workers' Compensation, Occupational Disease law, or similar law;

Organ Transplant Policy

Organ and tissue transplant coverage is provided under a separate insurance policy by Tokio Marine HCC.

– Stop Loss Group (TMHCC) and is issued either by National Union Fire Insurance Company of Pittsburgh,Pa. or HCC Life Insurance Company. Such coverage pays benefits for certain organ and tissue transplantswithout regard to any benefits that may or may not be provided by this Major Medical Plan. Please contact TMHCC's Transplant Unit toll-free at 1-888-449-2377 for benefit information, pre-authorization of transplantservices, and transplant network Provider access.

Pre-Authorization of Transplant Services

Pre-authorization of transplant services is required prior to seeing a transplant Provider for a consult and/orevaluation. Failure to do so could result in reduced benefits.

NOTICE - Transplant Network

In order to obtain 100% in-network benefits, you must use Providers in a transplant network approved by and accessed through TMHCC's Transplant Unit. Expenses billed by the transplant network Provider that are not covered by the TMHCC policy are subject to this Medical Plan's benefits and the payment terms and conditions of the transplant network Provider's contracted rates.

For more information, contact your Medical Plan Administrator and/or human resources department.

NOTE: The Company's fully insured Organ Transplant Policy is the Primary payer for Organ, Tissue and Bone Marrow Transplants. In the event the Company's Organ Transplant Policy does not cover some or all transplant related charges incurred by a Covered Person due to a pre-existing condition exclusion limitation, this Plan will consider the charges based on benefits below as the Secondary payer. See Coordination With Organ Transplant Policy section of this Plan Document.

Claim Review and Audit Program

The Plan has arranged with ELAP Services, LLC ("ELAP") for a program of claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services which are not medically appropriate. Benefits for claims which are selected for review and auditing may be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a usual, customary or reasonable fee determination.

Medical care providers will be given a fully detailed explanation of any charges that are found to be in excess of Allowable Claim Limits, and allowed the rights and privileges to file an appeal of the determination which are the same rights and privileges accorded to Plan Participants; and, in return, the provider must agree not to bill the Plan Participant for charges which were not covered as a result of the claim review and audit. This will in no way affect the rights of the Plan Participant to file an appeal under the Plan. Please refer to the section, "Procedures for Claims and Appeals" for additional information regarding Participant and provider appeals.

Any Plan Participant who receives a balance-due billing from a medical care provider for these charges should contact ELAP or the Plan Administrator right away for assistance.

The Plan Administrator is identified in the Third-Party Administrator section of the Health Insurance Summary Plan Description located at the beginning of the document. ELAP may be contacted at:

ELAP Services, LLC
1550 Liberty Ridge
Suite 330
Wayne, PA 19087
Phone: 610-321-1030; Fax 610-321-1031

The Plan Participant must pay for any normal cost-sharing features of the Plan, such as Deductibles, Coinsurance and Copayments, and any amounts otherwise excluded or limited according to the terms of the Plan.

The success of this program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount of Covered Medical Expense that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the provider of service and the Plan Participant. In the event that the Plan Administrator does not receive information adequate for the claim review and audit within the time limits required under applicable regulations, it will be necessary to deny the claim. Should such a denial be necessary, the Plan Participant and/or the provider of service may appeal the denial in accordance with the provisions which may be found in the section, "Procedures for Claims and Appeals" in this Summary Plan Description.

In the following provisions of the Claim Review and Audit Program, the term "Plan Administrator" shall be deemed to mean ELAP Services, LLC ("ELAP"):

"Allowable Claim Limits" means the charges for services and supplies, listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Examples of the determination that a charge is within the Allowable Claim Limit include, but are not limited to, the following guidelines:

1. Errors, Unbundled and/or Unsubstantiated Charges. Allowable Claim Limits will not include the following amounts:

a. Charges identified as improperly coded, duplicated, unbundled and/or for services not performed;
b. Charges for treating injuries sustained or illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator can be attributed to medical errors by the provider;
c. Charges that cannot be identified or understood; and
d. Charges that cannot be verified from audits of medical records.

2. Guidelines. The following guidelines will be used when determining Allowable Claim Limits:

a. Facilities. The Allowable Claim Limit for claims by a facility, including but not limited to, hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care facility, shall be the greater of (I) 112% of the facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. If insufficient information is available to identify either the facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.

b. Ambulatory Health Care Centers. The Allowable Claim Limit for ambulatory health care centers, including ambulatory surgery centers, which are independent facilities shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the Medicare allowed amount, the Allowable Claim Limit for such services shall be to the extent available either the outpatient or inpatient Medicare allowed amount for the service, plus an additional 20%.

c. Professional Providers. The Allowable Claim Limits for professional providers shall be determined using the following:

i. For general medical and primary care claims, the Medicare allowed amount in the geographic area plus an additional 40%;
ii. For specialist medical and surgical care claims, the Medicare allowed amount in the geographic area plus an additional 55%;
iii. For anesthesiologist claims, the Medicare allowed amount in the geographic area plus an additional 100%;
iv. For ambulance and air ambulance claims, the Medicare allowed amount in the geographic area plus an additional 20%; or
v. For other non-facility claims and supplies (such as, but not limited to, Durable Medical Equipment, laboratory services and supplies, and mid-level providers, etc.), the Medicare allowed amount in the geographic area.

For purposes of determining the proper Allowable Claim Limits for professional providers in categories

(i), (ii), (iii), (iv), or (v), above, the Plan Administrator shall determine the applicable category for each claim based on the taxonomy code used by the professional provider for that claim. The Plan Administrator determines in its sole discretion the type of provider for determining Allowable Claim Limits, as detailed above.

While this Plan typically pays professional providers based on the Medicare allowed amounts above, certain services may be reimbursed at 110% of the Medicare allowed amount for the service. These services may include, but are not limited to, routine diagnostic tests, evaluation services, telehealth and services for ongoing therapy. A full list of services subject to this rule can be found here: www.planlimit.com/prof1. This list will be updated at least annually to reflect the Plan's current plan design.

d. Directly Contracted Providers. The Allowable Claim Limits for Directly Contracted Providers shall be the negotiated rate as agreed under the Direct Agreement.

e. Insufficient Information to Determine Allowable Claim Limit. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above as may be applicable, ELAP may apply the following guidelines:

i. **General Medical and/or Surgical Services.** The Allowable Claim Limit for any covered services may be calculated based upon industry-standard resources including, but not limited to, published and publicly available fee and cost lists and comparisons, or any combination of such resources that in the opinion of the Plan Administrator results in the determination of a reasonable expense under the Plan.

ii. **Medical and Surgical Supplies, Implants, Devices.** The Allowable Claim Limit for charges for medical and surgical supplies made by a provider may be based upon the invoice price (cost) to the provider, plus an additional 12%. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the Plan Administrator.

iii. **Physician, Medical and Surgical Care, Laboratory, X-ray, and Therapy.** The Allowable Claim Limit for these services may be determined based upon the 90th percentile of Fair Health (FH®) Allowed Benchmarks.

Comparable Services or Supplies. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above, Allowable Claim Limits will be determined considering the most comparable services or supplies based upon comparative severity and/or geographic area to determine the Allowable Claim Limit. The Plan Administrator reserves the right, in its sole discretion, to determine any Allowable Claim Limit amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Person.

In the event that a determination of Allowable Claim Limit for a Claim exceeds the actual Charges billed for the services and/or supplies, the actual Charges billed for the Claim shall be the Allowable Claim Limit.

Prescription Drug Benefits Plan

Prescription Drug Copays apply to satisfy the Annual Out-of-Pocket Maximum. After the Annual Out-of-Pocket Maximum has been met, covered Prescription Drugs will be payable at 100% for the remainder of the Calendar Year.

Calendar Year Prescription Drug Deductible Per Covered Person	 $50
Prescription Card Service Supply Limit Generic Drugs Brand Name Drugs	**100% after applicable Copay** 34 days 20% Copay with a minimum of $5 and maximum of $100 20% Copay with a minimum of $20 and maximum of $100
Mail Order Service Supply Limit Generic Drugs Brand Name Drugs	**100% after applicable Copay** 90 days 20% Copay with a minimum of $5 and maximum of $100 20% Copay with a minimum of $40 and maximum of $100
Specialty Drugs* Supply Limit Generic Drugs Brand Name Drugs	**100% after applicable Copay** 30 days 20% Copay with a minimum of $5 and maximum of $100 20% Copay with a minimum of $20 and maximum of $100

*Specialty Drugs must be obtained through the Prescription Drug Plan's Specialty Pharmacy.

NOTE: Medications required for Preventive Care services may be covered at 100% with no Copay.

The Prescription Drug Deductible must be satisfied each Calendar Year before Copays apply. The Prescription Drug Deductible and Copays are waived for Drugs prescribed for the following chronic healthconditions including diabetes, asthma, cardiovascular disease, hypertension (high blood pressure) and hyperlipidemia (high cholesterol).

If the pharmacy charge is less than the Generic or Brand Copay, then the actual charge will become the Copay. Generic and Brand Name copayments apply separately to each prescription and refill and do not apply to the Calendar Year Deductible. To be covered, Prescription Drugs must be:

1. Purchased from a participating licensed pharmacist;
2. Dispensed to the Covered Person for whom they are prescribed; and
3. Legally prescribed by a Qualified Prescriber.

DEFINITIONS

Brand Name Drugs
Trademark Drugs or substances marketed by the original manufacturer.

Generic Drugs
Drugs or substances which:

1. Are not trademark Drugs or substances; and
2. May be legally substituted for trademark Drugs or substances.

Over the Counter (OTC) Drugs
Drugs which do not require a prescription from a Qualified Prescriber, unless otherwise specified.

Prescription Drugs
Legend Drugs or medicines which are prescribed by a Qualified Prescriber for the treatment of Illness, Injury or Pregnancy.

Qualified Prescriber
A licensed Physician, Dentist, or other health care Practitioner who may, in the legal scope of his/her practice, prescribe Drugs or medicines.

Specialty Drugs
Specialty pharmaceuticals include biotech Drugs produced using living organisms which are high cost or injectable Drugs that require heightened patient management and support.

Product Selection
The pharmacist substitutes more economically priced Generic equivalent Drugs whenever possible unless there is a specific request for a Brand Name by the prescribing Physician or when State law requires no substitution for the Brand Name Drug.

Most pharmacists, as a courtesy to the patient, will ask whether a Generic Drug is acceptable to the Covered Person if the Physician has specified “product selection permitted” on the prescription. If the Physician hasspecified “dispense as written,” no choice is given to the patient, and only the applicable Copay will be charged.

Miscellaneous Provisions
The following provisions may be included in your Prescription Drug Plan. Please contact the Prescription Card Service Customer Service phone number listed on the Plan Participant identification card for more information.

Step Therapy: The practice of starting Drug therapy (including Specialty Drugs) for a medical condition with the most cost-effective and safest Drug available, then progressing to other more costly alternatives ifnecessary. Patients currently working with their provider for a condition will be exempt from the corresponding Step Therapy program.

Therapeutic Substitution: A Physician-oriented service designed to increase the utilization of more cost-effective products. Substitutes are made for Brand Name Drugs with either Generic or similar Brand NameDrugs in the same therapeutic class.

Drug Review
The Plan includes a Drug Review program which is automatically administered by the pharmacist

through anationwide computer network that verifies the eligibility of each Covered Person's card and protects the Covered Person from conflicting prescriptions which might prove harmful if taken at the same time. This program also guards against duplication of medications and incorrect dosage levels.

Covered and Excluded Drugs:

The following Covered and Excluded Drug listings are not all inclusive. To find out if a particular Drugis covered, please contact the Prescription Card Service Customer Service phone number listed on the Plan Participant identification card.

NOTE: Some Drugs may require authorization and may only be covered, and/or covered for certain ages, if Medically Necessary.

Prescription Drug Plan – Covered Drugs

1. Legend Drugs (Drugs requiring a prescription either by Federal or State law) (there are certain LegendDrugs that may be excluded);
2. Insulin on prescription;
3. Disposable insulin needles/syringes, glucometers, test strips and lancets on prescription;
4. Compounded medications of which at least one ingredient is a prescription legend Drug up to $500;
5. All FDA approved women's contraceptive Drugs and methods ($0 Copay Generic only; if no Generic available, $0 Copay applies to Brand); and
6. Tobacco deterrent medications or any other tobacco use OTC cessation aids, all dosage forms ($0 Copay Generic only; if no Generic available, $0 Copay applies to Brand; two (2) 90-day supply limits per Calendar Year).

NOTE: Quantity limitations may apply to some Covered Drugs in addition to those shown above.

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional Drugsthat may be covered for preventive treatment.

Prescription Drug Plan – Drugs Requiring Authorization

1. Actiq;*
2. Acne medications, age twenty-six (26) and older;*
3. ADD/ADHD Drugs, age nineteen (19) and older;*
4. Growth hormones;*
5. Compounded medications of which at least one ingredient is a prescription legend Drug over $500; and
6. Specialty Drugs.*

* Covered with authorization if Medically Necessary.

Prescription Drug Plan – Excluded Drugs

1. Drugs for Cosmetic purposes;
2. Drugs prescribed for impotence/sexual dysfunction;
3. Fertility Drugs;
4. Weight loss medications;
5. Immunization agents (except immunizations and vaccines as required for Preventive Care services; $0Copay Generic only; if no Generic available, $0 Copay applies to Brand);, biological sera, blood or bloodplasma;
6. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medical substances, regardless of intended use, except those listed above;

7. Charges for the administration or injection of any Drug;
8. Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation laws;
9. Drugs labeled "Caution-limited by Federal law to Investigational use," or Experimental Drugs, even thougha charge is made to the individual;
10. Medication which is to be taken by or administered to an individual, in whole or in part, while he/she is a patient in a licensed Hospital, Extended Care Facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a Facility for dispensing pharmaceuticals; and
11. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed afterone (1) year from the Physician's original order.

NOTE: Drugs excluded from the Prescription Drug Plan are not payable under travel Benefits.

A Prescription Drug dispensed by a retail pharmacy, Mail Order Service or Specialty Pharmacy for which a Copay applies is not considered a Claim for benefits under this Plan and, therefore, is not subject to the Plan's Claim Filing Procedures.

When Alternative Care and treatment are identified by Case Management as Medically Necessary and approved by the Plan Administrator, and where there is a reasonable expectation of savings to the Plan without sacrificing the quality of care to the patient, the Plan may approve and pay for all, or part of the charges not shown as a Covered PrescriptionDrug in this Plan Document.

PRESCRIPTION DRUG UTILIZATION REVIEW

The Prescription Drug benefit does not have unlimited coverage. As with all medical and Hospital services, Prescription Drug utilization is subject to determinations of Medical Necessity and appropriate use. Drug Utilization Review may be concurrent, retrospective or prospective.

Concurrent Drug Utilization Review generally occurs at the time of service and may include electronic Claimaudits which may help to protect patients from potential Drug interactions or Drug-therapy conflicts or overuse/under use of medications.

Retrospective Drug Utilization Review generally involves Claim review and may include communication bythe Prescription Drug Plan and/or Utilization Review with the prescribing Physician to coordinate care andverify diagnoses and Medical Necessity. It may include a peer review by a Physician of like specialty to theprescribing Physician reviewing the medical and pharmacy records to determine Medical Necessity.

Should Medical Necessity not be determined by the peer review Physician, the treating Physician and Plan Participant will be notified and provided with the peer review results. The Plan Participant and Physician will be forwarded information on the appeal process as outlined in this Plan.

Prospective Drug Utilization Review may include, among other things, Physician or pharmacy assignmentin which one Physician and/or one pharmacy is selected to serve as the coordinator of prescription Drug services and benefits for the eligible Plan Participant. The Plan Participant will be notified in writing of this and will be required to designate a Physician and pharmacy as his/her Providers.

Comprehensive Dental and Orthodontic Expense Benefits

If, while a Covered Person, you or any of your Dependents incur covered dental expenses which, within a calendar year are in excess of the deductible amount, benefits will be paid to you, subject to the maximum benefit specified in the Dental Schedule of Benefits. Benefits will be determined by multiplying such excess expenses by the applicable coinsurance factor as shown in the Schedule.

Pre-determinations are available upon request. Please mail your pre-determination along with supporting documentation to the address on the back of the member's identification card. Emergency treatment, oral examination including prophylaxis and dental x-rays will be deemed a part of any succeeding course of treatment even though such services are performed before any Pre-determination of Benefits in accordance with this provision. If no Pre-determination of Benefits is submitted, benefits payable under these Comprehensive Dental Expense provisions will be determined as though such a pre-determination had been made, except that, to the extent that post-verification of a covered dental expense cannot be reasonably made, no benefit will be payable for that expense.

The total benefit which will be paid for a Covered Person's covered dental expenses will not exceed the maximum comprehensive dental expense benefit shown in the Schedule of Dental and Orthodontic Benefits.

"Dentists" means an individual holding a D.D.S. or D.M.D degree and licensed to practice dentistry in the jurisdiction where such services are provided to a Covered Person.

"Course of Treatment" means a planned program of one or more dentists or doctors for the treatment of a Covered Person's dental condition and commencing with date that the first such service is rendered.

"Alternate Benefits" means if alternate procedures, services, or courses of treatment can be performed to properly correct a dental condition, the maximum covered Dental Expense to be considered for payment will be for the Plan Administrator, produce a professionally satisfactory result.

A. Pre-Determination of Benefits:
Pre-determination of Benefits means the filing, in a form acceptable to Core Administrative Services of a dentist or doctor's diagnosis of a Covered Person's dental condition, the proposed course of treatment and the expected charges, in order that Core Administrative Benefits may estimate the benefits, if any, that would be payable under these Comprehensive Dental Expense provisions. You are responsible for furnishing the diagnostic and evaluative material requested by Core Administrative Services for its pre-determination of benefits. Core Administrative Services may at the Plan's expense, require an oral examination of the Covered Person by its own designated dentist or doctor. When a pre-determination of benefits has been made, Core Administrative Services will inform you or the attending dentist or doctor, in advance of treatment, as to the estimated amount of any benefits payable under these Comprehensive Dental Expense provisions with respect to the proposed course of treatment.

B. Covered Dental Expenses:
Covered dental expenses are Reasonable Charges made by a dentist or doctor for necessary dental treatment, listed below, except as may be limited in the section entitled LIMITATIONS. Whether a charge is reasonable

will be determined by the Plan Administrator. (See explanation of Reasonable Charges under the "Definitions" portion in this booklet.)

C. Deductible Amount:
For each covered person, the individual deductible amount shown in the Dental Schedule of Benefits, is the amount of covered dental expenses which must be incurred by a Covered Person within a calendar year before a benefit is payable for subsequent expenses incurred in that year.

Schedule of Dental and Orthodontic Benefits

MAXIMUM DENTAL BENEFITS	Benefit
Calendar Year Maximum Dental Benefit (Preventive, Basic and Major Services)	
Per Covered Person (age 19 and older)	$1,300
Per Covered Person (under age 19)	No Dental Maximum*
*Dental expenses for Covered Persons under age 19 are not subject to the Calendar Year Maximum Dental Benefit. Dental Expenses for Covered Persons under age 19 apply to the Annual Out-of-Pocket Maximum.	
Lifetime Maximum Orthodontic Benefit	
Per Covered Person	$1,500
DENTAL CALENDAR YEAR DEDUCTIBLE	
Per Covered Person	$50
BENEFIT PERCENTAGE	
Preventive Dental Services	100%; Deductible waived
Basic Dental Services	80% after Deductible
Major Dental Services	50% after Deductible
Orthodontic Services*	50% after Deductible
BENEFIT WAITING PERIOD	
*Benefits for Orthodontic Services begin the first day following **twelve (12) months** of continuous coverageunder the Plan.	

CALENDAR YEAR DEDUCTIBLE REQUIREMENT

The Covered Person is responsible for the Deductible amount. The Dental Calendar Year Deductible maybe satisfied by either Covered Basic Dental Services, Major Dental Services or Orthodontic Services. Payment of Basic, Major and Orthodontic Dental benefits will begin each Calendar Year after the Deductibleamount has been satisfied by Covered Charges. The Plan will not reimburse any charges applied to the Deductible.

There is no Deductible carryover for Covered Dental Expenses incurred and applied to the Deductible during the last three (3) months of a Calendar Year.

ALTERNATIVE TREATMENT

This Dental Plan has an "alternative treatment" clause that governs the amount of benefits the Dental Plan will pay for treatments covered under the Dental Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment that provides professionally satisfactory results at the most cost- effective level.

For example, if a regular Amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Customary Charge for an Amalgam filling. The patient will be responsible for the difference in cost.

NOTE: A temporary Dental Service will be considered an integral part of the final dental service rather than a separate service.

Preventive Dental Benefits

PREVENTIVE

1. Dental Prophylaxis (cleaning and Scaling of teeth) – Not more than two (2) cleanings per CoveredPerson each Calendar Year
2. Fluoride Treatment (covered to age 19) – limited to one (1) such treatment or series of treatments perCovered Person each Calendar Year
3. Sealants (covered to age 16)
4. Space Maintainers (covered to age 20):
   a. Fixed - unilateral and bilateral types
   b. Removable - unilateral and bilateral types
   c. Recementation of space maintainer

DIAGNOSTIC

Routine Oral Examination – Not more than two (2) examinations per Covered Person each Calendar Year

X-RAYS

1. Bitewings - Not more than one (1) series of films each Calendar Year
2. Intraoral periapical - films
3. Intraoral - occlusal films
4. Extraoral - films
5. Posterior/anterior or lateral skull and facial bone survey film
6. Complete Series (full mouth) –Not more than once every thirty-six (36) consecutive months
7. Panoramic - Not more than once every thirty-six (36) consecutive months

TESTS AND LABORATORY EXAMINATIONS

1. Caries susceptibility tests
2. Pulp vitality tests
3. Bacteriological studies
4. Screening for oral cancer- limited to once per Calendar Year

EMERGENCY PALLIATIVE TREATMENT

Palliative treatment of dental pain, minor procedures

<u>BASIC DENTAL SERVICES</u>

RESTORATIONS

1. Amalgam fillings (including polishing) - Pin Retention is exclusive of Amalgam
2. Silicate Cement per filling
3. Acrylic or Composite fillings:
   a. Acrylic
   b. Composite resin
   c. Pin retention - exclusive of Composite resin
   d. Composite resin (involving incisal angle)

REPAIRS AND OTHER RESTORATIVE SERVICES

1. Recement Inlays/Onlays
2. Recement Bridges and Crowns

ENDODONTICS

1. Root Canal Therapy (includes Treatment Plan, clinical procedures, and follow-up care; excluding finalRestoration)
2. Pulp Capping (excluding final Restoration)
3. Vital Pulpotomy (excluding final Restoration)
4. Apicoectomy - performed as separate Surgical Procedure (per root)

PERIODONTICS

1. Periodontal Evaluations
2. Periodontal Prophylaxis
3. Surgical Services (including usual postoperative services):
   a. Gingivectomy or gingivoplasty - per quadrant
   b. Gingival curettage
   c. Gingival flap procedure - per quadrant
   d. Osseous Surgery (including flap entry and closure) - per quadrant

e. Osseous graft - single site and multiple sites (including flap entry, closure, and donor site)
f. Free soft tissue grafts (including donor site)

4. Adjunctive Periodontal Services:
   a. Periodontal Scaling and root planing
   b. Full mouth debridement

MISCELLANEOUS SERVICES/APPLIANCE(S)

1. Problem Focused Exam
2. Dental Consultations (required by the attending Dentist)
3. Nitrous oxide
4. Antibiotic injections by the attending Dentist
5. X-rays and pathology to include panoramic survey (not in relationship to Preventive and Diagnostic)

ORAL SURGERY

1. Extractions - includes local Anesthesia and routine postoperative care
2. Surgical Extractions (except those performed for Orthodontic purposes) - includes local Anesthesia and routine postoperative care:
   a. Extraction of tooth
   b. Root recovery (surgical removal of residual root)
3. Other Surgical Procedures:
   a. Surgical exposure of impacted or unerupted tooth to aid eruption
   b. Biopsy of oral tissue (hard or soft)
   c. Incision and drainage
4. Alveoloplasty (surgical preparation of ridge for Dentures):
   a. Per quadrant - in conjunction with extractions
   b. Per quadrant - not in conjunction with extractions
5. Anesthesia
   a. Local anesthetic
   b. General anesthesia (only when Medically Necessary and when administered in conjunction withoral or Dental Surgery)
   c. IV sedation

<u>Major Dental Services</u>

RESTORATIONS

1. Gold Inlay Restorations:
   a. Inlay - gold, two (2) or three (3) surfaces
   b. Onlay - per tooth (in addition to above)
2. Inlay - Porcelain
3. Crowns:
   a. Plastic
   b. Porcelain
   c. Gold (full cast or 3/4 cast)
   d. Semi-precious metal (full cast)
   e. Non-precious metal (full cast)
   f. Crown buildups - pin retained

g. Cast post and core in addition to Crown
h. Dowel pin-metal per tooth (in addition to Abutment Crown)
i. Crown lengthening
j. Stainless steel

PROSTHODONTICS – REMOVABLE – FIXED

1. Complete Dentures - including six (6) months post-delivery care:
   a. Complete upper and/or lower
   b. Immediate upper and/or lower
2. Partial Dentures - including six (6) months post-delivery care:
   a. Upper or lower - without clasps, Acrylic base
   b. Upper or lower - with two (2) gold clasps with rests, Acrylic base
   c. Upper or lower - with gold palatal bar or gold lingual bar and two (2) clasps, Acrylic base
   d. Upper or lower - with gold palatal bar or gold lingual bar and two (2) clasps, cast base
   e. Removable unilateral Partial Denture one (1) piece gold casting, clasp attachments, per unit including Pontics
   f. Full cast partial - with two (2) gold clasps (upper and lower)
3. Additional Units for Partial Dentures:
   a. Each additional clasp with rest
   b. Each tooth (applies only to full cast partial)
4. Fixed Bridges (each Abutment and each Pontic constitute a unit in a Bridge)
5. Bridge Pontics:
   a. Casts
   b. Slotted facing or Pontic
   c. Porcelain fused to gold or non-precious metal
   d. Plastic processed to gold or non-precious metal
6. Retainers:
   a. Gold Inlay – two (2), three (3) or more surfaces
   b. Gold Inlay (onlaying cusps)

PROSTHODONTICS, REMOVABLE-ADJUSTMENTS, REPAIRS, REBASING AND RELINING

1. Adjustments to Dentures:
   a. Complete Denture
   b. Partial Denture – upper and/or lower
2. Repairs to Dentures (Complete and partials)
3. Denture Rebasing/Relining:
   a. Rebasing/Relining upper or lower complete or Partial Denture (office Reline)
   b. Relining upper or lower complete or Partial Denture (laboratory)
4. Tissue Conditioning

PROSTHODONTICS, FIXED – REPAIRS AND OTHER SERVICES

1. Repairs to Bridges
2. Recement Dentures

Orthodontic Services

ORTHODONTIC TREATMENT

"Orthodontic treatment" means the movement of teeth through bone by means of active Appliances whenrequired to correct a Malocclusion for either:

1. Overbite or overjet (vertical or horizontal overlap of upper teeth over lower teeth);
2. Maxillary and mandibular arches in either protrusive or retrusive relation;
3. Crossbite; or
4. Arch length discrepancy.

COVERED ORTHODONTIC SERVICES

1. Cephalometric x-rays - limited to one (1) time in any two (2) year period
2. Orthodontic Treatment - limited to Malocclusions including:
   a. Necessary services related to an active course of Orthodontic treatment
   b. Surgical exposure of impacted or unerupted teeth for Orthodontic reasons including wire attachment when indicated and extractions performed for Orthodontic purposes
   c. The initial and subsequent, if any, installation of Orthodontic Appliances for an active course of Orthodontic treatment, including retainers and cervical traction Appliances
   d. Adjustment of active Orthodontic Appliances
3. Study Models/Diagnostic casts - limited to one (1) Study Model per Covered Person
4. Diagnostic photos

DATE INCURRED

A Covered Orthodontic Expense will be deemed incurred:

1. For cephalometric x-rays or study models - on the date the service was rendered
2. For all other expenses - on the date of insertion of bands or Appliance or when bands or Appliance are in place at the time the Covered Person becomes effective under this Plan - on the date of monthlyadjustment

ORTHODONTIC TREATMENT PLAN

The Orthodontic Treatment Plan is the Dentist's report of recommended Orthodontic treatment on a formsatisfactory to the Claims Administrator which:

1. Itemizes the Orthodontic procedures and charges required for correction of a Malocclusion
2. Lists the Usual and Customary Charges for each procedure
3. Is accompanied by supporting x-rays and any other appropriate diagnostic materials as required

WHEN COVERAGE BEGINS

Subject to the “Waiting Period” section, benefits are payable for Covered Orthodontic Services incurred only after the Covered Person becomes effective under the terms of the Plan.

Orthodontic benefits are payable monthly over the Course of Treatment and cease upon termination ofcoverage.

Dental Plan Limitations and Exclusions

No payment will be made under the Dental Plan for the following:

Broken Appointments. Charges for dental appointments which are not kept.
Broken or Worn Appliances. Charges for replacement of broken or worn Appliances or Dentures or Bridgework, unless the Dentist certifies such equipment unserviceable and such equipment has been installed for a period of five (5) years.
Claim Received After Filing Deadline. Claims received after ninety (90) days from the date of renderedservice.
Close Relative. Charges for professional dental treatment, surgical services and supplies provided by a Close Relative of the Covered Person, as defined in this Plan.
Cosmetic Dentistry. Charges for or in connection with Cosmetic Dentistry to include care, treatment or operations which are performed for cosmetic, elective or non-functional purposes, unless such expenses are incurred as a result of an Accidental Injury. See Accidental Injury exclusion.
Dental Implant. Charges for any service or procedure associated with the placement, prosthodontic Restoration or maintenance of a Dental Implant.
Employer Dental Department Services. Charges for services and material received from a dental or medical department maintained by an Employer, a mutual benefit association, a labor union or a health and welfare fund.
Employment. Charges in connection with an Illness or Injury arising out of, or in the course of, any employment for wage or profit.
Excess of Usual and Customary. Charges made which are in excess of Usual and Customary fees or charges for unnecessary care or treatment.
Fees. Records fee, chart fee and insurance filing fee.
Furnished by Government. Charges for services or supplies furnished at the direction of the United States Government or any State, province, or other political subdivision, unless the covered individuals would be required to pay such charges in the absence of this coverage.
Government Hospital. Charges incurred in a Hospital owned or operated by the United States Government.
Harmful Habit Appliances. Charges for removable/fixed Appliances for harmful habits such as tongue thrust and thumb sucking.
Hospital Service. Charges for Hospital services when procedures are performed by a licensed Dentist orsurgeon. Hospital, Anesthesia and related charges, when Medically Necessary for a dental service, are covered by the Medical Plan.
Illegal Acts. Charges for Injury or Illness incurred as a result of illegal acts involving violence or threat of violence to another person, or in which the Covered Person illegally used a firearm, explosive or other weapon likely to cause physical harm or death, whether or not the Covered Person was charged, convicted or received any type of fine, penalty, imprisonment or other sentence or punishment, unless such Injury is the result of a medical condition (either physical or mental) or is the result of the Covered Person being the victim of an act of domestic violence.
Lost or Stolen. Charges for replacement of lost or missing or stolen Appliances or Dentures or Bridgework.
Not Furnished by a Dentist. Charges for any service or material not furnished by a Dentist, except a service performed by a licensed Dental Hygienist under the direction of a Dentist or any x-ray ordered by the Dentist.

Not Legally Required to Pay. Charges which you are not legally required to pay or for charges which would not have been made if no coverage existed.
Occlusal Guards. Charges for occlusal guards (nightguards) for bruxism.
Orthodontic Treatment. Charges for services during the first twelve (12) months of consecutive coverage.
Personalization. Charges for personalization or characterization of teeth or prosthetics.
Prescription Medication. Charges for prescription medication. However, certain prescriptions written by aDentist may be covered under the Prescription Drug Plan.
Prohibited by Law. Charges where prohibited by law.
Rebasing/Relining. Charges for Rebasing/Relining of partial or full removable Dentures for which like service was rendered within the two (2) years immediately preceding such Rebasing/Relining.
Replacement of Denture/Bridgework/Crown. Charges for partial or full removable Dentures or fixed Bridgework or for the addition of one (1) or more teeth thereto, or for a Crown or gold Restoration if involvinga replacement or modification of a Denture, Bridgework, Crown or gold Restoration which was installed during the five (5) years immediately preceding such replacement or modification.
Sealants and Oral Hygiene Instructions. Charges for Sealants (age sixteen (16) and over), oral hygiene instructions, dietary instructions, or a plaque control program, prescription Fluoride, mouthwashes or Topical oral solutions.
Splinting. Charges for Appliances, Inlays, cast Restorations, Crowns or other laboratory prepared Restorations used primarily for the purpose of Splinting, unrelated to Temporomandibular Joint (TMJ) Dysfunction.
Temporomandibular Joint (TMJ) Disorders. Charges for Appliances, Restorations and special equipmentused to treat TMJ dysfunction.
Travel. Charges incurred as the result of travel outside the United States or its territories specifically to receive dental treatment.
Vertical Dimension/Occlusion. Charges for Appliances, Restorations and special equipment used to increase Vertical Dimension or reconstruct Occlusion.
War. Charges for services or treatment of Illness or Injury incurred as a result of any act of war, whether declared or undeclared or caused during service in the armed forces of any country or resulting from or sustained as a result of participation in a riot or civil insurrection.
Workers' Compensation. Charges in connection with an Illness or Injury for which the covered individual isentitled to benefits under any Workers' Compensation or similar Local, State or Federal Statute, or to the extent the covered individual is entitled to benefits or payments under Automobile Personal Injury ProtectionInsurance issued pursuant to any No-Fault type automobile reparations ordinance or statute.

In the event that more than one (1) Dentist furnishes services or materials for one (1) dental procedure, thePlan shall be liable for not more than its liability had only one (1) Dentist furnished the services or materials.

DENTAL DEFINITIONS

Abutment: A tooth or root that retains or supports a fixed Bridge or a removable prosthesis.
Acid Etch: The etching of a tooth with a mild acid to aid in the retention of Composite filling material.
Acrylic: Plastic materials used in the fabrication of Dentures and Crowns and, occasionally, as a restorative filling material.
Amalgam: A metal alloy usually consisting of silver, tin, zinc and copper, combined with liquid pure mercury and used as restorative material in operative dentistry.
Anesthesia: Local - the condition produced by the administration of specific agents to achieve the loss of pain sensation in a specific location or area of the body; General - the condition produced by the administration of specific agents to render the patient completely unconscious and without pain sensation.
Appliance: A device used to provide function, therapeutic (healing) effect or space maintenance, or as anapplication of force to teeth to provide movement or growth changes, as in Orthodontia: Fixed - one that isattached to the teeth by cement or by adhesive materials and cannot be removed by the patient; Removable
- one that can be taken in and out of the mouth by the patient; Prosthetic – one that is used to provide replacement for missing teeth.
Bitewing: A type of dental x-ray file that has a central tab or wing upon which the teeth close to hold the film in position. They are commonly called decay detecting x-rays because they show decay better than other x-rays.
Bridge or Prosthetic Appliance: Fixed - Pontics or replacement teeth retained with Crowns or Inlays cemented to natural teeth and used as Abutments; Fixed removable - one the Dentist can remove but the patient cannot; Removable - a Partial Denture, retained by attachments which permit removal of the Denture, normally held by clasps.
Caries: A Disease of progressive destruction of the teeth from bacterially produced acids on tooth surfaces.
Composite: Tooth colored filling material primarily used in the anterior teeth.
Cosmetic Dentistry: Dentally unnecessary procedures performed solely for the improvement of a person'sappearance.
Course of Treatment: A planned program of one (1) or more services or supplies, whether rendered by one (1) or more Dentists for the treatment of a dental condition diagnosed by the attending Dentist. A Course of Treatment begins on the date a Dentist first renders a service to correct or treat the diagnosed dental condition.
Crown: Natural Crown - the portion of a tooth covered by enamel; artificial Crown (cap) - restores the anatomy, function and aesthetics of the natural Crown.
Dental Hygienist: A person who has been trained and licensed to clean teeth and provide additional services and information on the prevention of oral Disease and who works under the direct supervision of a Dentist.
Dentist: A Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD) who holds a lawful license authorizing the practice of dentistry in the locale where service is rendered.
Denture: A device replacing missing teeth. The term usually refers to full or Partial Dentures, but it actuallymeans any substitute for missing natural teeth.

Emergency Palliative Treatment: Any dental procedures necessary to alleviate (but not cure) acute pain or to temporarily alleviate (but not cure) conditions requiring the immediate attention of a

Dentist to prevent irreparable harm to the Covered Person.

Endodontic Therapy: Treatment of Diseases of the dental pulp and their canals: Root Canal Therapy andpulp canal therapy.

Fluoride: A solution of fluorine which is applied to the teeth for the purpose of preventing dental decay.

Frenectomy: Surgical cutting of any Frenum, usually of the tongue.

Frenum: Muscle fibers covered by a mucous membrane that attaches the cheek, lips and/or tongue to associated dental mucosa.

Implant: A device surgically inserted into or onto the jaw bone that may support Crown(s), a Partial Denture or complete Denture, or be used as an Abutment for a fixed Bridge.

Impression: A negative reproduction of a given area. It is made in order to produce a positive form or castof the recorded teeth and/or soft tissues of the mouth.

Incurred Date:

1. For an Appliance or modification of an Appliance, the date the Impression is taken;
2. For a Crown, Bridge or gold Restoration, the date the tooth is prepared;
3. For Root Canal Therapy, the date the pulp chamber is opened; and
4. For all other services, the date the service is provided.

Inlay: A Restoration, usually of cast metals, made to fit a prepared tooth cavity and then cemented into place.

Malocclusion: An abnormal contact and/or position of the opposing teeth when brought together.

Occlusion: The contact relationship of the upper and lower teeth when brought together.

Onlay: A cast Restoration that covers the entire chewing surface of the tooth.

Orthodontia: The branch of dentistry primarily concerned with the detection, prevention and correction ofabnormalities in the positioning of the teeth in their relationship to the jaws.

Palliative: An alleviating measure used to relieve but not cure.

Partial Denture: A prosthesis replacing one or more, but less than all, of the natural teeth and associatedstructures. It may be removable or fixed and on one or both sides of the mouth.

Pedodontics: The specialty of Children's dentistry.

Periodontics: The examination, diagnosis and treatment of Diseases affecting the tissue surrounding andsupporting the teeth.

Pontic: The part of a fixed Bridge which is suspended between the Abutments, and which replaces a missing tooth or teeth.

Prophylaxis: The removal of tartar and stains from the teeth or the cleaning of the teeth by a Dentist or Dental Hygienist.

Prosthodontics: Dental specialty providing artificial replacement of one (1) or more natural teeth and/or the associated structure.

Rebase: A process of refitting a Denture by the replacement of the entire Denture-base material without changing the occlusal relations of the teeth.

Reline: To resurface the tissue-borne areas of a Denture with new material.

Restoration: A broad term applied to any Inlay, Crown, Bridge, Partial Denture or complete Denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape, form and function of part or all of a tooth or teeth.

Root Canal Therapy: Complete removal of the pulp tissues of a tooth, sterilization of the pulp chamber androot canals and filling the spaces with a sealing material.

Scaling: Removal of calculus (tartar) and stains from teeth with a special instrument.

Sealant: A resinous agent applied to the grooves and pits of teeth to reduce decay.

Silicate: A relatively hard and translucent restorative material used primarily on the anterior teeth.
Splinting: Stabilizing or immobilizing teeth to gain strength and/or facilitate healing.
Splints: Device used to support, protect or immobilize oral structures that have been loosened, replanted,fractured or traumatized.
Temporomandibular Joint (TMJ) Disorders: Abnormal functioning of the Temporomandibular Joint; alsorefers to symptoms arising in other areas secondary to the dysfunction.
Topical: Painting the surface of teeth, as in Fluoride treatment, or application of an anesthetic formula to the surface of the gum.
Treatment Plan: A Dentist's report on a form satisfactory to the Claims Administrator which:

1. Itemizes the dental services recommended by the Dentist for the necessary dental care of a person;
2. Shows the Dentist's charge for each dental service; and
3. Is accompanied by supporting pre-operative x-ray(s) or other diagnostic records where required or requested by the Claims Administrator.

Usual and Customary:
1. The Usual fee - the fee most frequently charged or accepted for covered dental care or supplies by a Dentist, Physician or Hospital; and
2. The Customary fee - the fee charged or accepted for covered dental care or supplies by those of similarprofessional standing in the same geographic area; "area" means a region large enough to determine across section of Providers of dental care or supplies.
Vertical Dimension: The degree of jaw separation when the teeth are in contact.

Notification Requirements

If a Covered Person fails to call Core Health Services (CHS) within the time limits specified below, the Covered Person will be subject to a penalty of $500.

Notification is <u>not</u> a guarantee of benefits, only that the procedures are medically necessary. Any days that are not certified by utilization review as medically necessary will <u>not</u> be covered.

This Plan covers only charges that are Medically Necessary for the care and treatment of disease or injury. To determine Medical Necessity, Notification must be made to CHS within 48 (forty-eight) hours following the date of service for any of the services listed in the services that Requires Notification Section.

The Employee, patient, family member, Employer, attending Physician, or Hospital can contact CHS for Notification at 478-741-3521 or 888-741-CORE (2673). A nurse case manager is available to take calls Monday through Friday, 8am - 5pm EST, and the caller is able to leave a message after hours.

It is the patient's responsibility to notify CHS. **To avoid a penalty and obtain maximum benefits, Notification must be done within the following time limits:**

1. **Scheduled Inpatient or Outpatient Treatment** – This includes all hospitals and ambulatory surgery centers and specialized Treatment Facilities (Oncology Centers, Dialysis Facilities, etc.). Maternity admissions (see separate Maternity Admissions) also require notification. Notification of Treatment must be made at least 48 (forty-eight) hours after the date of service.

2. **Maternity Admissions** – This Plan, under federal law, generally may not 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 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, this Plan may not, under federal law, require that a provider attain authorization from the Plan for prescribing a length of stay not in excess of (48) hours (or ninety-six (96) hours as applicable).

   Any Maternity Hospital stays longer than (48) hours (or ninety-six (96) hours as applicable) must notify CHS and will be subject to the Notification penalties as defined in the Notification Requirements.

3. **Emergency or Urgent Inpatient or Outpatient Admissions** – The Plan does not require Notification for emergency services in the ER of a hospital (even if the emergency services are provided out-of-network). The Plan will:
   - not impose any administrative requirement or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network providers for emergency services.
   - not impose out-of-network copays or coinsurance requirements that exceed in-network levels.
   - impose other cost-sharing requirements (such as deductible or out-of-pocket maximums) only if the requirement applies generally to out-of-network benefits (not just emergency care). Further, out-of-network providers are permitted to balance bill patients for the difference between the provider's charge and the amount the provider receives from The Plan and the patient's regular copayment or coinsurance amount.

   Cost-sharing requirements expressed as a copayment amount or coinsurance rate imposed for out-of-network emergency services cannot exceed the cost-sharing requirements that would be imposed if the services were provided in-network.

   For out-of-network providers, The Plan will pay an amount equal to the greatest of the following:
   a) the amount negotiated with in-network providers (note that if network providers have negotiated different rates, this number will be the median of all those rates);
   b) the amount calculated under its normal out-of-network method (such as usual, customary and reasonable) but substituting the in-network cost-sharing provisions; or
   c) the amount Medicare would have paid.

   If in-network providers are paid on a capitation basis, the first item above is ignored and the plan must pay out-of-network providers based on the greater of the second two items.

   A Hospital confinement following an emergency or urgent admission undergoes concurrent review just like a scheduled admission.

Any Emergency or Urgent Inpatient or Outpatient Admission stay lasting longer than (48) hours must be reported and may be subject to the Notification penalties as defined in Notification Requirements.

4. **Durable Medical Equipment** – all medical equipment in excess of $500 in purchase price require Notification to CHS.

When you call for Notification, a CHS nurse case manager will ask for the necessary information. Following is a list of the necessary information for Notification:

1. Employee's name and social security number;
2. Patient's name, date of birth, sex, and contact telephone number;
3. Facility or Hospital's name, address, and telephone number;
4. Admitting Physician's name, address, and telephone number;
5. Date of admission;
6. Diagnosis and/or surgical procedure (if known); and
7. Date of surgery.

Any additional information needed will be obtained from the attending Physician or Hospital by the CHS nurse case manager. All medical information is kept confidential. In some instances, CHS may suggest alternative modes of treatment or recommend a second surgical opinion. CHS can help reduce personal inconvenience and limit the increasing cost of medical care by eliminating unnecessary or questionable services. If it is determined that the Hospital confinement is Medically Necessary, your attending Physician, Hospital, and you will receive a notice of certification.

If there is a question about the scheduled procedure, treatment, or length of confinement, a CHS Physician will review your case. If the CHS Physician also has questions, he or she will contact your Physician for additional information. If you do not agree with the denial of your request, please see the **Process for Appealing a Denied Medical Claim and/or Notification** if you received an adverse benefit determination.

Services that Require Notification:

The following items require Notification:

- *Biopsy, radiation therapy, chemotherapy, transplant, and dialysis*
- *Bone Density Study – if part of complete physical exam*
- *Bronchoscopy*
- *Cat Scan (CT)*
- *Colonoscopy (Lower GI)*
- *Colposcopy*
- *DME over $500*
- *Echocardiogram*
- *Electroencephalogram (EEG)*
- *Electromyogram (EMG)*
- *Genetic Testing*

- *Heart Catheterization – If elective or if admitted*
- *HIDA Scan*
- *Inpatient stay*
- *MRI*
- *Nerve Conduction Studies*
- *Nuclear Scan*
- *Observation Stay*
- *Orthognathic/TMJ*
- *Outpatient surgery (unless listed below)*
- *PET Scan*
- *Sleep Studies*
- *Therapies: pulmonary rehabilitation and speech therapy*

The following items do not require Notification:

- *Cardiac Stress Test*
- *Cataract Surgery*
- *Esophagogastroduodenoscopy (EGD) [Upper GI]*
- *Electrocardiogram (EKG)*
- *Mammogram*
- *Pap Smear*
- *Ultrasound*
- *X-rays*

You are required to obtain authorization for certain procedures that might be cosmetic or not medically necessary for the treatment of illness or injury. All requests for these procedures should be made in writing and should be submitted well in advance of the planned procedure date:

- *Blephareplasty*
- *Breast reduction or mammoplasty*
- *Dermatolipectomy*
- *Diastasis recti repair (tummy tuck)*
- *Hernia repairs, all except inguinal*
- *Incision of the maxilla or mandible*
- *Keloid removal*
- *Mastectomy for gynecomastia*
- *Mentoplasty*
- *Otoplasty*
- *Panniculectomy*
- *Penile Implant*
- *Rhinoplasty*
- *Sclerotherpy*
- *Uvulopalatopharyngoplasty (UPPP)*
- *Varicose Vein ligation/stripping*

Concurrent Review

Following notification of a Hospital/Facility admission, a Concurrent Review of treatment will be conducted by Utilization Review. "Concurrent Review" means Utilization Review will monitor the Covered Person's Hospital stay and periodically evaluate the need for continued hospitalization. In addition, Utilization Review may assist with discharge planning and address the health care needs of the patient upon release. This may involve consultation with the Covered Person's Physician and comparison of clinical information to nationally accepted criteria.

Core Health Services
P.O. Box 90
Macon, GA 31202-0090

Notification does not guarantee benefits. Payment of benefits is subject to any subsequent reviews of medical information or records, the patient's eligibility on the date the service is rendered, and any other contractual provisions of the Plan.

Case Management

During the utilization review process, certain medical cases such as transplants, burns, spinal cord Injuries, cancer and other large cases will be identified, and Case Management may be initiated. Case Management may be provided by Nurses and or Physicians with specialized training and/or advanced national certification. The Nurse may monitor the medical care, consult with the Physicians, coordinate with the health care Providers and Facilities, and communicate with the patient and Family directly in order to promote receipt of appropriate, cost-effective care and to expedite the recovery process.

When Out-of-Network fees are negotiated by Case Management on behalf of the Plan, Out-of-Network Covered Charges may be considered at the In-Network PPO Benefit level.

ALTERNATIVE CARE

Through alternative care, Case Management may help the patient and the Plan Administrator obtain care/treatment for a serious Illness or Injury that is Medically Necessary and appropriate for the diagnosis.When alternative care and treatment are identified by Case Management as Medically Necessary and approved by the Plan Administrator, and where there is a reasonable expectation of savings to the Plan without sacrificing the quality of care to the patient, the Plan may approve and pay for all, or part of the charges not shown as a Covered Expense or as a Covered Prescription Drug in this Plan Document. These expenses will be considered on the same basis as the care and treatment for which they are substituted. Benefits provided under this section are subject to all other limitations and provisions within the Plan. In exercising its authority, this Plan will act in a way so as not to discriminate against any Plan Participant. If the care is not being substituted for other Covered Expenses, it will be considered on the same basis as asame or similar Covered Expense or Covered Prescription Drug shown in this Plan Document, asdetermined by the Claims Administrator.
All benefits provided in this section are subject to Medical Necessity, Reasonableness, Usual and Customary charges or the Allowable Claim Limits under the Claim Review and Audit Program.

COORDINATION OF CARE

Coordination of Care may be indicated for medical treatment that is Medically Necessary, not Experimental and does not require UR Notification. Coordination of Care is provided by a Registered Nurse (RN) to assist the Plan Participant with coordination of medical care, prevent duplicate diagnostic testing and/or treatment and identify and refer patients with diagnoses that would benefit from further Plan programs such as Case Management, Disease Management and/or Maternity Support.

Core Clinical Advisor: Information, Questions or Assistance

Members are able to call and speak with Core's Medical Director or a Registered Nurse in our Utilization Management Department. Our health care professionals are available to discuss a wide variety of topics concerning your current health or treatment plan.

Eligibility and Effective Date of Coverage

Employee Eligibility

A full-time Employee of the Employer who is in Active Service on or subsequent to the effective date of this Plan and who has completed any waiting period specified by the Employer; excluding in any case part-time Employees, temporary Employees, and Employees who work fewer than thirty-seven and a half (37 1/2) hours per week. If an Employee is an individual proprietor or partner, the owner or partner may be included only while they are actively engaged in and devoting substantial time to the business of the Participating Employer.

If an Employee qualifies as both, an Employee and a Dependent, such person may only be covered as one of the above and not both an Employee and a Dependent.

Effective Date of Employee Coverage

Coverage will become effective for an Employee as indicated below, provided the Employee is in Active Service on that date; otherwise, the effective date will be deferred until the date following a return to Active Service.

Coverage for an Employee whose employment commenced on or before the Plan effective date and who was validly covered by a plan provided by the Employer, which was replaced by this Plan, will become effective on the Plan effective date, if on that date the waiting period, as specified in the SUMMARY PLAN DESCRIPTION section, has been satisfied.

Coverage for any other Employee will become effective on the first day of eligibility as specified in the SUMMARY PLAN DESCRIPTION.

Each Employee will be covered on the above Effective Date provided enrollment and any required contributions have been made within thirty-one (31) days after the date of eligibility.

Dependent Eligibility

The following persons shall be eligible to be covered as Dependents under this Plan:

1. The lawful spouse of the Employee. The term spouse shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship;
2. An employee's child from the date of birth to age twenty-six (26) regardless of the child's financial dependency, residency, student, employment and/or marital status.

The Plan is NOT required to extend coverage to any child or Spouse of a Covered Dependent child.

An intellectually disabled or physically handicapped child may continue coverage beyond the limiting age. For further details, please refer to Incapacitated Child and to the EXTENDED COVERAGE FOR DEPENDENT CHILDREN sections.

The term "child" includes the following subject to the age limits and requirements specified above:

1. Natural (biological) Child; or
2. Child who has been legally adopted or placed for adoption with the Covered Employee; or
3. Stepchild; or
4. Child who has been placed under the legal guardianship or conservatorship of the Covered Employee.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights. At any time, the Plan may require proof that a Spouse or child qualifies or continues to qualify as a Dependent as defined by the Plan.

All other persons are excluded.

If both parents of any Dependent child are covered Employees, then for the purposes of this Plan, the Dependent child can be Dependent of one parent only.

An Employee will be eligible to enroll for Dependent coverage on whichever of the following dates is first to occur:

1. The date the Employee is eligible for coverage, if on that date the Employee has such Dependents;
2. The date the Employee first gains a Dependent (see EFFECTIVE DATE OF COVERAGE FOR NEWBORN CHILDREN section for details on newborns).

Effective Date of Dependent Coverage

Coverage will become effective for a Dependent, other than a Newborn Child, as indicated below, provided both the Employee and Dependent are in Active Service on that date and the Dependent is not confined in a hospital, other institution or home on that date; otherwise, the effective date will be deferred until the day following a return to Active Service. A Dependent's effective date will be determined as follows:

1. The date on which the Employee becomes covered if there are any Dependents on that date;

2. If the Employee is without a Dependent on the date the Employee becomes covered, Dependent coverage will become effective on the day of eligibility, provided enrollment for coverage is made within thirty-one (31) days after the Dependent is acquired and any required contribution is paid within thirty-one (31) days after the Dependent is acquired.
3. If the Employee has Dependent coverage, coverage for any newly acquired Dependents (see EFFECTIVE DATE OF COVERAGE FOR NEWBORN CHILDREN section for details on newborns) will become effective on the day of eligibility, provided that enrollment is made within thirty-one (31) days of the date that the Dependent is acquired and required contribution is paid within thirty-one (31) days after the Dependent is acquired. This will be allowed under the Special Enrollment Period.
4. Each Dependent will be covered on the above effective date provided enrollment and any required contributions have been made within thirty-one (31) days after the date of eligibility.

Effective Date of Coverage for Newborn Children

A Newborn Child will automatically become covered from birth (as long as an enrollment card is completed) if Dependent coverage is in force at the time of birth. The Employee may be required to make an additional contribution if needed for the newborn within thirty-one (31) days after the date of birth depending on previous benefit selections. Coverage will be provided to the same extent as for other Covered Dependent children. If at the time of birth, the Covered Employee is acquiring the first Dependent, the Employee must enroll for Dependent coverage within thirty-one (31) days after the date of birth.

The Employee must make an additional contribution for the newborn from the date of birth if required by this Plan. If this is done, Dependent coverage will become effective as of the date of birth under the Special Enrollment Period provision.

If a Newborn Child is not enrolled within thirty-one (31) days after the date of birth, the newborn may not be enrolled until the following Annual Open Enrollment period unless there is another Change in Family Status prior to the Annual Open Enrollment period.

Enrollment Requirements

Timely Enrollment

Initially eligible Employees must enroll for coverage within thirty (31) days of completing your waiting period, by completing, signing and submitting an enrollment application along with the appropriate payroll deduction authorization. Should enrollment be received after that time frame, the eligible Employee will be treated as a Late Enrollee.

Special Enrollment Period

The thirty (31) day period of time surrounding a loss of other coverage for a Special Enrollee, or the thirty (31) day period of time after a Dependent is acquired due to birth, adoption or marriage.

1. **Individuals losing other coverage**. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions are met:

- The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time of coverage under this Plan was previously offered to the individual.
- If required by the Plan Administrator, the Employee stated in writing at the time this coverage was offered, their other health coverage was the reason for declining enrollment.
- The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or Employer contributions towards the coverage were terminated.
- The Employee or Dependent requests enrollment in this Plan not later than thirty-one (31) days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the Employee or Dependent lost the other coverage as a result of the individuals' failure to pay premiums or required contributions or for cause (such as making fraudulent claim), that individual does not qualify as a Special Enrollee.

2. **Dependent Beneficiaries**. If:
    - The Employee is a participant under this Plan (or has met the waiting period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period) and
    - A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption, then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a Covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employees may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of thirty-one (31) days and begins on the date of the marriage, birth, adoption or placement for adoption.
The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

- in the case of marriage, as of the actual date of marriage; or
- in the case of a Dependent's birth, as of the date of birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Late Enrollment

An enrollment is “late” if it is not made on a “timely basis” or during a Special Enrollment Period. Late Enrollees and their Dependents that are not eligible to join the Plan during a Special Enrollment Period may join only during the annual or open enrollment period.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individuals is a Late Enrollee. The time between the dates a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period.

Change in Classification of a Covered Employee

Any change in the amount of an Employee's coverage resulting from a change in the Employee's classification shall become effective on the effective date of change, provided the Employee is in Active Service on that date.

Change in Classification of a Covered Dependent

Any change in the amount of a Dependent’s coverage resulting from a change in the Employee’s classification shall become effective on the on the effective date of change, provided the Employee is in Active Service on that date.

Qualified Medical Child Support Order (QMCSO)

QMCSOs obligate a noncustodial parent by a child support order to provide medical support for his or her children. QMCSOs require group health plans to provide benefits to a child of a participant.

Please contact CAS or your Human Resources Department for more information.

Changing Coverage During the Plan Year - FAMILY STATUS CHANGES

The employee is permitted to make changes in coverage during the Plan Year only in the event of certain specified “Changes in Status”. “Changes in Status” which would permit the Employee to make a change in coverage are as follows:

1. Marriage
2. Divorce
3. Birth or Adoption of a Child, or the assumption of legal responsibility for a Stepchild.
4. Death of an enrolled Dependent
5. Dependent Child reaches age 26
6. Dependent Child becomes employed full-time and if offered coverage with their employer
7. Dependent Child becomes totally or permanently disabled
8. Covered Dependent loses coverage under an outside Plan or suffers a substantial change in coverage under the outside Plan
9. Covered Dependent experiences a change in employment status

The request to add or delete coverage must be made within 31 days of the Change in Status. Failure to

delete coverage for Dependents no longer eligible for coverage within the 31-day period will not result in premiums being reimbursed for that period of time when the premiums were paid and the Dependents were not eligible, nor will claims be paid for expenses incurred during such period. See also section entitled Continuation of Coverage (COBRA).

In the event of any of the above occurrences, the Employee should notify Benefits Administration and ask for the appropriate forms necessitated by the Change in Status.

Effective Date of Coverage Change due to a Change in Family Status:

For a Marriage, Birth, or Adoption of a Child or acquisition of responsibility for a Step Child, the Effective Date of the Change will be the date of the change itself. For all deletions of cover age, the change will be effective on the date of the change itself.

Coverage Changes

FOR EMPLOYEES PARTICIPATING IN THE SECTION 125 PLAN

Contributions to the Plan can be made on a "Salary Reduction" basis under Section 125 of the Internal Revenue Code. This allows premium contributions to be withheld from the Employee's paycheck on a "pre-tax" basis before any Federal Income Tax or FICA taxes are calculated.

The Annual Election Period for the Section 125 Plan is the same as the Annual Open Enrollment Period forthe Employee Health Plan. Annual Open Enrollment Dates and Effective Date of Coverage can be found in the PLAN DOCUMENT SUMMARY.

1. Once an election is made to participate, this election can only be changed during the next year's AnnualOpen Enrollment Period for the Plan.

A coverage change is allowed in the Medical/Dental Plan if there is a change in status due to certain eventsincluding, but not limited to, any of the following:

Status Changes

- Marriage
- Divorce or legal separation (in those States recognizing legal separation)
- Birth or adoption of a Child
- Death of spouse or Child
- Commencement of spouse's or Dependent's employment
- Termination of spouse's or Dependent's employment
- Open enrollment for spouse's/Dependent's Employer plan
- Significant cost or coverage changes for Employee, spouse or Dependent
- Change from part-time to Full-time Employment (or vice-versa)/reduction or increase in hours
- Unpaid Leave of Absence
- Change in the residence or worksite
- Dependent satisfies or ceases to satisfy the eligibility requirements for coverage
- Qualified Medical Child Support Order (QMCSO)
- Entitlement to or loss of eligibility for Medicare or Medicaid
- Entitlement to or loss of eligibility for a State Children's Health Insurance Program (CHIP)

- Open enrollment of a Marketplace Qualified Health Plan (QHP) as outlined by the Affordable Care Act(ACA)

An election change may be made only if a recognized Status Change for cafeteria plans will result in the gain or loss of eligibility for coverage of the Employee, the Employee's spouse or Dependent.

A written request for addition or deletion of coverage due to a Status Change must be made within thirty-one
(31) days of that change or the exception will not apply. However, a request for addition or deletion of coverage due to a change in eligibility under Medicaid or a State Children's Health Insurance Program (CHIP) must bemade within sixty (60) days of that change.

Tag Along Rule: If, due to a Status Change, an Eligible Employee enrolls in health coverage or a CoveredEmployee elects to increase health coverage, at that time, the Eligible Employee or the Covered Employee may also enroll his/her spouse and/or Eligible Dependents who were not previously covered for health careregardless of whether such individuals personally experienced the Status Change.

Effective Date of Coverage Following Status Change
Most Status Changes qualify for Special Enrollment. See the Employee and Dependent Special EnrollmentPeriods section.

If there is a Status Change which does not qualify for a Special Enrollment Period as outlined in the Employee and Dependent Special Enrollment Periods, the effective date of coverage under the Medical Plan will be the date of the Status Change.

FOR EMPLOYEES NOT PARTICIPATING IN THE SECTION 125 PLAN

A request for coverage change (addition or deletion of coverage) can also be made when premium contribution is withheld from the Employee's paycheck on an after-tax basis. A written or electronic requestfor deletion of coverage can be made by completing a Change Form. Deletion of coverage is subject to thePlan's Termination provisions. A written or electronic request for addition of coverage can be made subjectto the Plan's Annual Open Enrollment, Eligibility, Effective Date, Special Enrollment Period and Late Enrollee provisions.

Termination Date of Coverage

Termination of Employee Coverage

A covered employee's coverage will terminate immediately upon termination of this Plan or on the date indicated in the SUMMARY PLAN DESCRIPTION section, after the occurrence of the first of the following events:

1. The date employment terminates;
2. The date the Employee ceases to be eligible or ceases to be in a class of Employees eligible for coverage;
3. The date the Employee fails to make any required contribution for coverage;

4. The date the Plan is terminated; or with respect to any Employee's benefit of the Plan, the date of termination of such benefit;
5. The date the Employee enters the Uniformed Services of the United States or armed forces of any country or international organization on a full-time active duty basis if active duty is to exceed thirty-one (31) days;
6. The date the Employee requests termination of coverage, unless prohibited by law (i.e., when electionchanges cannot be made due to Internal Revenue Code Section 125 "change in status" guidelines)." NOTE: The Employer may offer these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and, if so, a voluntary termination must comply with the requirements of the Code and the cafeteria plan;
7. The date the Employee fails to return to Full-time Employment following an approved Leave of Absence.See Coverage During Leave of Absence section;
8. The date the Employee takes an unapproved Leave of Absence from work; or
9. The date the Employee dies.

Termination of Dependent Coverage

A Covered Dependent's coverage will terminate immediately upon termination of this Plan or on the date indicated in the SUMMARY PLAN DESCRIPTION section, after the occurrence of the first of the following events:

1. The date the Dependent (other than a Dependent Child age twenty-six (26) or older) ceases to be anEligible Dependent as defined in the Plan;
2. The date of termination of the Employee's coverage under the Plan;
3. The date the Employee ceases to be in a class of Employees eligible for Dependent coverage;
4. The date the Employee fails to make any required contribution for Dependent coverage;
5. The date the Plan is terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefit;
6. The date the Employee or Dependent enters the Uniformed Services of the United States or armed forces of any country or international organization on a full-time active-duty basis if active duty is to exceed thirty- one (31) days;
7. The date the Employee requests termination of Dependent coverage, unless prohibited by law (i.e., when election changes cannot be made due to Internal Revenue Code Section 125 "change in status" guidelines)." NOTE: The Employer may offer these benefits in conjunction with a cafeteria plan underSection 125 of the Internal Revenue Code and, if so, a voluntary termination must comply with the requirements of the Code and the cafeteria plan;
8. The date the Employee fails to return to Full-time Employment following an approved Leave of Absence.See Coverage During Leave of Absence section;
9. The date the Employee takes an unapproved Leave of Absence from work;
10. The last day of the month in which the Dependent Child reaches age twenty-six (26);
11. The date the unmarried adult Dependent Child age twenty-six (26) or older for whom coverage is beingcontinued due to the Child being Physically Handicapped or Intellectually Disabled and incapable of earning his/her own living, upon the earliest to occur of: a. cessation of such inability; b. failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; c. the Child no longer being dependent on the Employee for his/her support; or d. the Child's marriage. However, if such earliest event

occurs before the last day of the month in which suchDependent Child reaches age twenty-six (26), then coverage will terminate on the last day of the monthin which such Dependent Child reaches age twenty-six (26); or

12. Forty-five (45) days following the date the Employee dies.

Extended Coverage for Dependent Children

A child age twenty-six (26) and older who is physically handicapped or intellectually disabled may qualify for coverage beyond the age when other dependent coverage would end as long as ALL the following requirements are met:

1. The child is severely disabled by prolonged physical or mental incapacity;
2. The child became disabled prior to reaching age twenty-six (26);
3. The child was covered by the Plan prior to reaching age twenty-six (26), or, if older than age twenty-six (26), loses coverage under a parent's plan. In the event of loss of coverage, proof of coverage must be provided;
4. The child is unmarried and the covered employee provides more than 50% of his or her support because he or she is unable to earn a living due to intellectual disability or physical handicap.

For the dependent child to qualify, notice must be given to the Third-Party Administrator within thirty-one (31) days after the date dependent coverage would normally end.

The extension of coverage will continue as long as the incapacity continues, the covered employee maintains dependent coverage, and this Plan remains in full force and effect. Proof of handicap may be required periodically.

Children who become disabled after age twenty-six (26) are not eligible for coverage.

Family and Medical Leave Act of 1993 (FMLA)
(Requirement for employers with 50 or more employees)

If a covered Employee ceases Active Service due to an approved Family Medical Leave of Absence in accordance with all policies and procedures in effect governing such Leave, health coverage will be continued under the same terms and conditions which would have been provided had the covered Employee continued in Active Service, for a period of time not to exceed twelve (12) weeks, provided the Employee continues to pay any premiums normally required for coverage, either by prepayment or at the same time as payments would have been due.

Spouses employed by the same Employer are jointly entitled to a combined total of twelve (12) work-weeks of family leave for the birth and care of the Newborn Child, for placement of a child for adoption or foster care, and to care for a parent who has a serious health condition. Leave for birth and care, or placement for adoption or foster care must conclude within twelve (12) months of the birth or the placement.

Said premiums will remain at the same level as on the date immediately prior to the Leave, unless this Plan experiences a premium change for its entire Plan.

If the covered Employee does not return to Active Service after the approved Family Medical Leave or if the Employee has given the Employer notice of intent not to return to Active Service during the Leave Period, coverage may be continued under the CONTINUATION OF COVERAGE (COBRA) provision of this Plan, provided Coverage has not lapsed, effective with the date notification is given by the Employee to the Employer, and provided the covered Employee elects to continue such Coverage under that provision. The time period that coverage was continued during the Family Medical Leave will not be counted toward the maximum time that coverage can be continued under COBRA.

If the Employee fails to make the required premium contribution for coverage to continue during the Leave within thirty (31) days after the date the premium was due, coverage may be continued under the COBRA provisions of this Plan as of the date the coverage lapsed. COBRA continuation of coverage must be elected during this time in order for coverage to be continued. If Coverage under this Plan is terminated during an approved Family Medical Leave due to non-payment of required premiums by the Employee, and the Employee returns to Active Service immediately upon completion of the Leave Period, coverage will be reinstated on the date the Employee returns to Active Service without having to satisfy any waiting period provision of this Plan provided the Employee makes any necessary premium contributions and re-enrolls for coverage within thirty-one (31) days of the return to Active Service.

Approved Leaves of Absence are:

1. For the birth of the Employee's child and to care for the Newborn Child;
2. For placement with the Employee of a son or daughter for adoption or foster care;
3. To care for the Employee's Spouse, son, daughter or parent with a serious health condition;
4. For a serious health condition that makes the Employee unable to perform the functions of the job;
5. For qualifying exigencies arising out of the fact that the Employee’s Spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard or Reserves in support of a contingency operation;
6. For a serious injury or illness of the Employee’s Spouse, son, daughter, parent or next of kin of a covered service member.

An Employee is eligible for FMLA leave if he or she has at least twelve (12) months of service with the Employer and if he or she has worked at least 1,250 hours during the twelve (12) month period preceding the start of the leave.

Coverage During Leave of Absence

If, after depletion of sick leave, vacation time or Paid Time Off (PTO), whichever is appropriate (if any), active work ceases due to an Employer approved non-medical temporary Leave of Absence, lay-off, an Employer approved Medical and Disability Leave, an approved Leave of Absence subject to the Family and Medical Leave Act (FMLA), an approved leave as a reasonable accommodation under the Americans with Disabilities Act (ADA) or approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave), the Plan Administrator may, while the Plan is in force, continue the Employee’s coverage(Employee and

Dependent) during the period after cessation of active work due to:

1. Employer approved non-medical temporary Leave of Absence, or lay-off, but not to extend beyond theend of the third (3rd) calendar month following the date last worked, provided any required Employee contributions are made; or

2. Employer approved Medical and Disability Leave of Absence, but not to extend beyond the end of thethird (3rd) calendar month following the date last worked, provided any required Employee contributionsare made; or

3. Approved Family and Medical Leave (FMLA), but not to exceed a period of twelve (12) weeks (or twenty- six (26) weeks in the case of a Family service member medical leave) provided any required Employeecontributions are made;

4. An Employer approved thirty (30) day Personal Leave, available to Employees with a minimum of six (6)months of employment, provided any required Employee contributions are made; or

5. Approved leave as a reasonable accommodation under the Americans with Disabilities Act (ADA), as amended, for the timeframe approved by the Employer when leave is the only available accommodation; or

6. Approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave) for up to the minimum amount of time required by such State law provided any required Employee contributions are made.

The above Employer approved non-medical Leave of Absence and Employer approved Medical and DisabilityLeave are concurrent with, and are not in addition to, the twelve (12) week (or twenty-six (26) weeks in the case of a Family service member medical leave) approved Family and Medical Leave (FMLA), an approved leave as a reasonable accommodation under the Americans with Disabilities Act (ADA) or the minimum amount of time required by an approved leave required by applicable State law (Family, Medical, Disabilityand/or other temporary leave).

NOTE: If applicable State law requires a longer Leave of Absence than FMLA or any other approved Leaveof Absence, then State law will prevail.

If the Employee has not returned to Employment that meets the eligibility requirements after completion of an approved Leave of Absence, or if the Employee notifies the Employer that he/she will not be returning to Employment that meets the eligibility requirements following the Leave of Absence, coverage terminates and COBRA continuation becomes available on the basis of reduction in hours. See Continuation of Group Health Coverage (COBRA) section. Failure of the Employee to make any required Employee contributions duringan approved Leave of Absence will also result in termination of coverage.

Family and Medical Leave is subject to the requirements of the Family and Medical Leave Act (FMLA).

Nondiscriminatory Coverage as outlined by Section 1557 –
We do not discriminate on the basis of race, color, national origin, sex, age or disability. For the purpose of compliance with ACA Section 1557 we will define sex discrimination to include the basis of: an individual's sex; pregnancy (including false pregnancy, termination of pregnancy or recovery therefrom); childbirth and related medical conditions; gender identity; sex stereotyping.

Coverage After Termination

Continuation of Coverage – Consolidated Omnibus Budget Reconciliation Act (COBRA)
(Plans with 20 or more Employees)

When Plan coverage terminates due to a Qualifying Event, a Covered Employee or covered Dependent is a Qualified Beneficiary and eligible to elect continued group health coverage ("COBRA coverage"). COBRA coverage is the same health coverage that applies to Covered Employees and covered Dependents underthe Plan. However, the individual electing COBRA coverage must pay the full cost of the coverage plus anadministrative fee of 2%.

The length of time COBRA coverage can be continued is based upon the date of and the applicable Qualifying Event as described below:

Qualified Beneficiary	Qualifying Event	Maximum Coverage Period
Covered Employee and/or monthsCovered Dependent	Loss of coverage due to termination of employment (other than for gross misconduct) or reduction in hours	18
Disabled Covered Employee months*and/or Disabled Covered Dependent and each Qualified hoursBeneficiary who is not disabled*	Loss of coverage due to termination of employment (other than for gross misconduct) or reduction in	29
Covered Dependent	Loss of coverage due to divorce, legal separation or death of Employee	36 months
Covered Dependent	Loss of coverage due to Dependent Child losing eligibility as a Dependent Child	36 months
Covered Dependent	Loss of coverage due to Covered Employee's entitlement to Medicare(See Special Medicare Entitlement Rule section.)	36 months

QUALIFIED BENEFICIARY

A Qualified Beneficiary also includes a Child born to or placed for adoption with a former Covered Employee/Qualified Beneficiary during the period of COBRA coverage. Newborns and adopted Children offormer Covered Employees/Qualified Beneficiaries have independent COBRA rights and can remain on thePlan even if the former Covered Employee/Qualified Beneficiary drops coverage.

SOCIAL SECURITY DISABILITY

If a Covered Employee or a covered Dependent is determined to be disabled, as defined in the Social Security Act, on the date of the termination of employment or reduction in hours, or at any time during the first sixty (60) days of COBRA Continuation Coverage, the disabled person may be entitled to continue COBRA coverage for up to twenty-nine (29) months from the date of termination of employment or reduction in hours, provided the Social Security Administration determines, during the initial eighteen (18) month coverage period, that the individual is disabled. To qualify for the eleven (11) month extension of the maximum coverage period, the disabled person must provide the Plan Administrator with a copy of the Social Security Administration determination letter within sixty (60) days of receipt of same, and not later than the expiration of the original eighteen (18) month initial coverage period.

The cost of COBRA coverage for an individual entitled to extended coverage due to Social Security Disability for the period after the end of the eighteen (18) month COBRA coverage period will increase to 150% of the full cost for active participants.

SECONDARY QUALIFYING EVENTS

If COBRA coverage is elected by a covered Dependent based on the Covered Employee's loss of coveragedue to termination of employment or reduction in hours and a second Qualifying Event (divorce, legal separation, death or a Dependent Child losing eligibility as a Dependent Child) occurs during the eighteen
(18) month COBRA coverage period, the covered Dependent's maximum COBRA coverage period will begin on the date of the first Qualifying Event and continue for a thirty-six (36) month period. For example: If a Covered Employee terminates employment on December 31, 2016, the Employee's covered Dependent elects COBRA coverage, and the former Employee dies before July 1, 2018 (that is prior to the end of theoriginal eighteen (18) month COBRA coverage period), the maximum COBRA coverage period for the Dependent who elected COBRA coverage is extended until December 31, 2019.

SPECIAL MEDICARE ENTITLEMENT RULE

Entitlement to Medicare is not considered a traditional secondary Qualifying Event for a covered Dependent; however, Medicare entitlement does provide potentially longer periods of continuation coverage to certainQualified Beneficiaries based on the sequence of events. If a Covered Employee becomes entitled to Medicare, but the Employee is still a full-time active Employee, this event is not a COBRA Qualifying Event since Medicare entitlement alone does not

cause a loss of coverage. If the Covered Employee voluntarilyterminates employment after the Medicare entitlement date, the loss of coverage triggers a potential eighteen (18) month COBRA continuation period for all Qualified Beneficiaries. While the CoveredEmployee is only entitled to eighteen (18) months of COBRA Continuation Coverage, the other Qualified Beneficiaries (spouse and/or Dependent Children) are entitled to eighteen (18) months or thirty-six (36) months, measured from the date of the Employee's Medicare entitlement, whichever is greater.

EMPLOYEE RESPONSIBILITIES

COBRA coverage is not automatic upon the occurrence of a Qualifying Event. COBRA coverage must be elected as described below. In addition, a Covered Employee or a covered Dependent is responsible for notifying the Plan Administrator within sixty (60) days after the date of the QualifyingEvent if the Qualifying Event is the loss of coverage due to divorce, legal separation, or a DependentChild losing eligibility as a Dependent Child. A change form may be obtained from the Employer. Failure to provide such notice will result in loss of eligibility to elect COBRA coverage.

A Qualified Beneficiary must elect COBRA coverage no later than sixty (60) days after the date the eligibleindividual is sent an election form describing his/her right to elect continuation coverage (COBRA ElectionPeriod). If a Qualified Beneficiary elects coverage during the sixty (60) day COBRA Election Period, coverage is continuous from the time coverage would otherwise have been lost. A properly completed election formmust be returned to the Plan Administrator, signed, and dated, by the end of the COBRA Election Period.

If premium payment is not sent with the election form, initial premium payment for COBRA coverage must be received no later than forty-five (45) days after the date COBRA coverage was elected. Initial payment mustcover the retroactive monthly coverage period beginning with the date of loss of coverage. **Coverage willnot become effective until initial premium payment is received.**

Coverage will remain in effect if subsequent premiums are paid no later than thirty (30) days after the due dates of such payments. **Failure to pay premiums within the time periods specified will result in termination of COBRA coverage. Once continuation is terminated, the coverage cannot be reinstated.** If timely payments of the premium are made to the Plan in an amount that is not significantly less than theamount the Plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for continuation coverage, unless the Plan notifies the

Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (30 days) for payment of the deficiency to be made. For purposes of this section an amount not significantly less than the amount the Plan requires to be paid shall be defined as not more than the lesser of $50 or 10% of the required payment amount.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA coverage, for a Qualified Beneficiary who elects such coverage, will terminate prior to the completion of the eighteen (18) month, twenty-nine (29) month, or thirty-six (36) month period previously described upon one of the following occurrences:

1. The Qualified Beneficiary becomes covered by another group health plan **after** the date of COBRAelection;
2. Required contributions are not paid by or on behalf of the Qualified Beneficiary in a timely manner;

3. The Qualified Beneficiary becomes entitled to benefits under Medicare **after** the date of COBRA election;
4. The Qualified Beneficiary makes a request, in writing, to terminate coverage; or
5. The Plan Sponsor ceases to provide any group health plan to any similarly situated Employee.

NEW DEPENDENTS

If during the eighteen (18) months, twenty-nine (29) months or thirty-six (36) months, if applicable, of COBRA coverage, a Qualified Beneficiary acquires new Dependents (such as through marriage), the new Dependent(s) may be added to the coverage according to the provisions of the Plan. However, the new Dependents do not gain the status of a Qualified Beneficiary and will lose coverage if the Qualified Beneficiary who added them to the Plan loses coverage.

An exception to this is a Child who is born to, or a Child who is placed for adoption with, the Covered Employee Qualified Beneficiary. If the newborn or adopted Child is added to the Covered Employee's COBRA Continuation Coverage, then, unlike a new spouse, the newborn or adopted Child will gain the rights of all other Qualified Beneficiaries. The addition of a newborn or adopted Child does not extend the eighteen (18) or twenty-nine (29) month coverage period. Plan procedures for adding new Dependents canbe found in the Eligibility and Effective Date sections of this Plan. Premium rates will be adjusted at that time to the applicable rate.

OPEN ENROLLMENTS

Should an Open Enrollment Period occur during the COBRA continuation period, the Plan Administrator will notify the COBRA Participant of that right as well. If an Open Enrollment Period occurs, the Qualified Beneficiary will have the same rights to select the coverage and any of the options or plans that are availablefor similarly situated non-COBRA Participants.

TIMING OF THE ELECTION NOTICE

If a Qualifying Event is the Covered Employee's loss of coverage due to termination of employment, reduction in hours, death or Medicare entitlement, the Plan Administrator has forty-four (44) days to notify the Qualified Beneficiary of the right to elect COBRA coverage or, if applicable, the Plan Administrator must notify the COBRA Administrator within thirty (30) days of the Qualifying Event, and the COBRA Administrator has fourteen (14) days to notify the Qualified Beneficiary of the right to elect COBRA coverage.

Uniformed Services Employment and Reemployment Rights Act

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances (the rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service):

1. The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
    a. The twenty-four (24) month period beginning on the date on which the absence begins; or
    b. The day after the date on which the person was required to apply for or return to a position
2. A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be require to pay more than the Employee's share, if any, for the coverage.
3. An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed services.

In general, you must meet the same requirement for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Rehires / Reinstatement of Coverage

An Employee, whose employment/coverage was terminated and who resumes employment with the Company within a six (6) month period immediately following the date of such termination, shall become eligible for reinstatement of coverage on the first day following the date he/she resumes employment, provided a new enrollment form has been completed and returned to the Human Resources Department within thirty- one (31) days following rehire date and his/her Dependents shall also become eligible for reinstatement on that date. The reinstated Employee and his/her Dependents will not be subject to the Waiting Period for new Employees.

NOTE: An exception applies for a terminated Employee on COBRA who is rehired and returns to work afterexpiration of the above reinstatement period. Coverage will be continuous from the second day he/she resumes employment with no Waiting Period applied.

An Employee whose coverage would terminate due to active duty in the Uniformed Services of the UnitedStates, and who qualifies for military leave under the Uniformed Services Employment and ReemploymentRights Act (USERRA), will be reinstated on the date he/she resumes employment with the Company provided that such resumption of

employment is within the time period specified in USERRA.

The reinstatement procedures following a USERRA military leave are subject to the requirements of USERRA.

Instructions for Submission of Claims

Be sure the bills submitted include all of the following:

1. Employee's name, social security number and home address;
2. Patient's name, social security number and date of birth;
3. Employer's Name;
4. Name and address of the physician or Hospital
5. Physician's diagnosis;
6. Itemization of charges;
7. Date the injury occurred or illness began; and
8. Receipt for payment if reimbursement is to be made to the insured.

These items are REQUIRED in order to accurately pay claims. Certain claims may require additional information before being processed. Benefits payable under this Plan for any loss other than for which this Plan provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss.
All payments will be issued directly to the provider of the service unless receipted bills showing payment has been made are submitted. Please direct all claims and questions regarding claims to:

Core Administrative Services, Inc.
P.O. Box 90
Macon, GA 31202-0090
(478) 741-3521
(888)-741-CORE (2673)

Every attempt will be made to help Covered Persons understand their benefits; however, any statement made by an Employee of CAS or the Employer will be deemed a representation and not a warranty.

Actual benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing. All benefit payments are governed by the provisions of the Summary Plan Description.

Benefits may not be assigned to another party, including the right to bring legal action. A direction to pay a provider, directly or otherwise, is not an assignment of any right and that a direction to pay does not extend to a provider any legal right to initiate court proceedings.

If a definite answer to a specific question is required, please submit a written request, including all

pertinent information and a statement from the attending Physician (if applicable), and a written reply will be sent, which will be kept on file.

Claim Provisions

Time Limit for Submitting Claims

Written proof of loss must be submitted within one (1) year of the date charges are incurred to be considered eligible for payment. Upon termination of the Employer's agreement with the Third-Party Administrator (claims payer), written proof of loss must be submitted within ninety (90) days of the date the termination occurred to be considered eligible for payment. A charge will be deemed incurred on the date services are actually rendered or supplies are actually received.

If it was not reasonably possible to submit the claim in the time required, the claim will not be reduced or denied solely for this reason, if the claim is submitted as soon as reasonably possible. To be accepted, the claim must be submitted no later than one year from the date of loss unless the Covered Person was legally incapacitated.

Right to Investigate Claims

The Plan Sponsor acting on their behalf retains the right to request any medical information from any provider of service it deems necessary to properly process a claim.

A Physician designated by the Plan Sponsor will have the right and opportunity to examine, at its expense, any person whose Illness or Injury is the basis for any claim, when and as often as reasonably required and, in the event of death, to make an autopsy, unless prohibited by law.

Process of Appealing a Denied Medical Claim and/or Notification

If a claim is denied, in whole or in part, you or your Authorized Representative may file a written appeal for review of their claim with Core Administrative Services within 180 days after receiving notice of denial.

You or your Authorized Representative may submit a written statement, documents, records, and other information. Any reference to "you" in this section includes a covered person and his/her Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Medical Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your "Authorized Representative." Core Administrative Services has the right to refuse to review the medical claim if it is not appealed within 180 days after receiving notice of denial from the Claims Administrator. Bringing an appeal within applicable timelines is a prerequisite to filing a lawsuit in court regarding the claim.

Submit the following information with your appeal:

Name of person filing appeal: _____

Person filing the appeal is: _____

(List one of the following) the Covered Person, Patient or Authorized Representative

Member's Name: _____ **Member's ID:** _____

Contact information of person filing appeal (if different from patient)
Address: _____
Daytime phone: _____
Email: _____

Are you requesting an urgent appeal? Yes or No

Briefly describe why you disagree with this decision *(attach additional information, such as a physician's letter, bills, medical records, or other documents to support the claim):*

_____

_____

_____

Send your denial notice to: Core Administrative Services, PO Box 90, Macon, GA 31202

Core Administrative Services will notify you of the first-level decision on their appeal for denial of:

- *Claims for Urgent Care*, as soon as possible but no later than 36 hours after an appeal is received.
- *Claims for non-Urgent Care,* no later than 15 days after an appeal is received.
- *Denial of other claims,* no later than 30 days after an appeal is received.

If your first level appeal is denied, you will then have 60 days after receiving notice of the denial to appeal the denial to the second level appeal stage. A second level appeal decision will be issued to you within the same time period set out above for the timing of first-level appeal decisions, that is, within:

- 36 hours for claims for Urgent Care,
- 15 days for claims for non-Urgent Care, and
- 30 days for other claims.

If you do not appeal the denial of their first level appeal to the second level appeal stage, you have not completed the administrative appeal process and you will not be allowed to request a Voluntary External Review as described below. Nor will you be able to bring a lawsuit in court regarding their claim.

Voluntary External Review Appeal for Medical Claims

Please note that the provisions in this External Review section apply only to medical benefits claims. These provisions, however, do not apply to dental benefits, which for purposes of this section are excluded benefits.

If Core Administrative Services denies your appeal after you have followed the plan's appeal

procedures (or you are deemed to have exhausted the internal claim appeal process), you may have the option to file a voluntary appeal for external review by an independent review organization. You may submit a request for external review of the denial only if the denial involves: 1) medical judgment (including but not limited to requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that treatment is experimental or investigational), as determined by the external reviewer. Denial determinations on the basis that you failed to meet enrollment or eligibility requirements under the plan are not subject to review by the external review process.

The request must be filed with the Core Administrative Services within four months after the date of receipt of the denial decision. If there is no corresponding date four months after the date of receipt of the denial decision, the request must be filed by the first day of the fifth month following the receipt of the denial decision. If the last filing date falls on a weekend or Federal holiday, the filing date is extended to the next week day that is not a weekend or Federal holiday.

Within five business days following the date of receipt of the external review request, Core Administrative Services will complete a preliminary review of the request to determine whether:

- the claim was covered under the plan at the time the health care item or service was requested or, in the case of retrospective review, was covered under the plan at the time the health care item or service was provided;
- the denial decision does not relate to the claimant's failure to meet enrollment and eligibility requirements under the terms of the plan;
- you have exhausted the plan's internal appeal process unless you are not required to exhaust the internal appeals process under applicable final regulations; and
- you have provided all the information and forms required to process an external review.

Within one business day after completing the preliminary review, Core Administrative Services shall issue a written notice to you as to whether your claim is eligible for external view. If you request is complete but not eligible, the notice will include the reasons for it ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272) at the Department of Labor. If the request is not complete, the notice will describe the information or materials needed to make the request complete. You will be allowed to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notice, whichever is later.

If your request for external review is complete and eligible, it will be assigned to an independent review organization ("IRO") that has been accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. Core Administrative Services has contracted with IROs and uses unbiased methods for selecting the IRO for your claim.

The IRO will provide you a written notice of your request's eligibility and acceptance for

external review which will include a statement that you may submit with ten business days after receipt of the notice additional information that the IRO must consider when conducting its review. The IRO is not required to, but may consider, information submitted after ten business days. Within five business days after assignment of the IRO, the plan shall provide the IRO the documents and information considered in making the denial decision. If the plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the denial decision. The IRO shall notify you and the plan of its decision with one business day after it is made. The IRO shall forward information submitted by you to the plan within one business day. Upon receipt of the information, Core Administrative Services may reconsider its denial decision and if it decides to reverse its decision, notify you and the IRO within one business day after making such a decision. The IRO shall terminate its external review upon receipt of such notice.

The IRO will review your claim once more and not be bound by any decisions or conclusions reached during the plan's internal claim and appeal process. In addition to the documents and information provided, the IRO to the extent such information is available and the IRO considers them appropriate, will consider the following in its decision:

- your medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and documents submitted by the plan, you and your treating provider;
- the terms of the plan;
- appropriate practice guidelines, which must include applicable evidence-based standards and may include other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- applicable clinical review criteria developed ad used by the plan, unless the criteria are inconsistent with terms of the plan or applicable law; and
- the opinion of the IRO's clinical reviewer after considering documents and information to the extent they are available and the clinical reviewer considers them appropriate.

The IRO shall provide written notice of the final external review decision to you and the plan within 45 days after the IRO receives the request for external review. The IRO's decision shall include the following:

- a general description of the reason for the request for external review, including information sufficient to identity the claim (including the dates of service, health care provider, claim amount if applicable, the diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial);
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decisions;

- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance established under the Public Health Services Act Section 2793.

After a final review decision, the IRO shall maintain records of the claim and notices for six years. Such records are available for examination by you, the plan or applicable governmental laws.

Upon receipt of a final external review decision reversing a denial decision, the plan shall immediately provide coverage or payment for the claim.

Expedited External Review Process for Denied Claims

If your claim is eligible for the external review process, you may request an expedited external review if:

- an Initial Determination involves a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- a final internal appeal decision involves a medical condition where the timelines for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the appeal decision concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, Core Administrative Services shall determine whether the request meets the reviewability standards set for preliminary reviews under the Standard External Review Process discussed above. Core Administrative Services shall immediately send you a notice that complies with the requirements for standard external reviews as to whether your request for an expedited external review is eligible.

If your request for an expedited external review is complete and eligible, it will be assigned to an IRO. Core Administrative Services shall provide all necessary documents and information considered in making its denial decision to the IRO electronically or by telephone or facsimile or other available expeditious method. The IRO, to the extent information or documents are available and the IRO considers them appropriate, shall consider the documents and information described above for standard external reviews. The IRO shall review the claim once more and is not bound by any decision or conclusions reached during the Plan's internal claims and appeals process.

The IRO shall provide a notice of its final expedited external review decision in accordance with

the requirements for standard external review decisions as expeditiously as your medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours of the notice, the IRO shall provide written confirmation of the decision to you and the plan.

Limitations Period for Lawsuits

In order to bring a lawsuit in court regarding your claim, you must file suit within two years after your appeal (or external review, if you requested one) is denied or, if earlier, the date your cause of action first accrued. If a different limitations period is specified in an insured plan's contract, then that limitations period applies to that plan.

Provider of Service Appeal Rights

A Claimant may appoint the provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a Claimant to a provider of service will not constitute appointment of that provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the provider in the same manner as a Claimant's appeal, and will respond to the provider and the Claimant with the results of the review accordingly. Any such appeal from a provider of service must be made within the time limits and under the conditions for filing an appeal specified under the section regarding appeals, below. **Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Medical Expenses directly from the Plan, waiving any right to recover such expenses from the Claimant, and comply with the conditions of the section, "Claim Provisions," above.**
For purposes of this section, the provider's waiver to pursue Covered Medical Expenses does not include the following amounts, which will remain the responsibility of the Claimant:

- Deductibles;
- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the Plan;
- Charges for services and supplies which are not included for coverage under the Plan; and
- Amounts which are in excess of any stated Plan maximums or limits. **Note: This does not apply to amounts found to be in excess of Allowable Claim Limits, as defined in the section, "Claim Review and Audit Program."** The provider must agree to waive the right to balance bill for these amounts.

Also, for purposes of this section, if a provider indicates on a Form UB92 or on a CMS – 1500 Form (or similar claim form) that the provider has an assignment of benefits, then the Plan will require no further evidence that benefits are legally assigned to that provider.

Contact the Claims Administrator or the Plan Administrator for additional information regarding provider of service appeals.

Coordination of Benefits

If a Covered Person is covered under more than one group plan, including this Plan and any other group medical benefits provided through or by the Employer, and one or more other plans, as defined below, the benefits will be coordinated. The benefits payable under this Plan for any Claim Determination Period, will be either its regular benefits or reduced benefits which when added to

the benefits of the other plan, will equal no more than 100% of the Allowable Expenses, also defined below:

Coordination of Benefits Definitions

Allowable Expenses
Any Medically Necessary, reasonable item of expense incurred by a Covered Person, which is covered at least in part under this Plan.

Claim Determination Period
A Calendar or Plan Year or that portion of a Calendar or Plan Year during which the Covered Person for whom claim is made has been covered under this Plan.

Plan
Any plan under which medical or dental benefits or services are provided by:

1. Group, blanket or franchise insurance coverage;
2. Preferred Provider Organization (PPO);
3. Wholly or partially self-insured or self-funded group plans;
4. Group coverage under labor-management trusted plans, union welfare plans, Employer organization plans or Employee benefit organization plans;
5. Coverage, including Medicare, under governmental programs or coverage required or provided by a statute, or provided by or required by statute, including no-fault auto insurance. (Refer to the EFFECT OF MEDICARE provision for treatment of this coverage under this Plan).

Health Maintenance Organization Coverage
This Plan will not consider as an Allowable Expense any charge which would have been covered by a Health Maintenance Organization (HMO) had a Covered Person for whom the HMO would be primary payer, used the services of an HMO Participating Provider. Nor, will this Plan consider any charge in excess of what an HMO provider has agreed to accept as payment in full.

Order of Benefit Determination
When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the Allowable Expense. No plan pays more that it would without the Coordination of Benefits Provision.
A plan without a Coordination of Benefits provision is always the Primary Plan. If all plans have such a provision:

1. The plan covering the person directly, rather than as an Employee's Dependent, is primary and the others are secondary;
2. Dependent children of parents not separated or divorced:
    a. The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second;
    b. If both parents have the same birthday, the plan which covers the parent the longer period of time, pays first. However, if the other plan does not have this

rule but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. Dependent children of separated or divorced parents:
   When parents are separated or divorced, their birthday rules do not apply. Instead:
   a. The plan of the parent with custody pays first;
   b. The plan of the Spouse of the parent with custody (the step parent) pays next; and
   c. The plan of the parent without custody pays last.
   d. Unless the divorce decree specifies order of benefit determination, in which case, the order will be determined by the divorce decree.
4. Active/Inactive Employee: The plan covering a person as an Employee who is neither laid off nor retired (or as that person's Dependent) pays benefits first. The plan covering that person as a laid off or retired Employee (or as that person's Dependent) pays benefits second. If both plans do not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
5. If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time period pays second.

Recovery

If the amount of the payment made by this Plan is more than it should have paid, the Plan has the right to recover the excess from one or more of the following:

1. The person this Plan has paid or for which it has paid;
2. Insurance companies;
3. Other organizations.

Payment to Other Carriers

Whenever payments, which should have been made under this Plan in accordance with the above provisions, have been made under any other plan, this Plan will have the right exercisable alone and in its sole discretion to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, this Plan will be fully discharged from liability.

Release of Information

For the purposes of determining the applicability of and implementing the terms of the above provisions of this Plan or any similar provision of another plan, the Third-Party Administrator may, without the consent of or notice to any Covered Person, release to or obtain from, any information concerning any Covered Person, which is necessary for those purposes subject to the limitations outlined in the notice of Privacy Practices.

Any person receiving benefits under this Plan must furnish to the Third-Party Administrator information about other coverage which may be involved in applying this Coordination of Benefits provision.

If this Plan contains a prescription benefit card, NO Coordination of Benefits will apply for

Prescription Drug Coverage.

Effect of Medicare

THE FOLLOWING PROVISIONS APPLY TO THIS PLAN IF TWENTY (20) OR MORE EMPLOYEES ARE COVERED:

Active Employees and Spouses Age 65 and Older

When an Employee in Active Service who is age sixty-five (65) or older and when the Covered Dependent Spouse of any such Employee who is age sixty-five (65) or older becomes eligible for Medicare, the individual must choose one of the following options:

Option 1. Primary coverage under this Plan (Under this option, benefits provided under this Plan will be paid without regard to Medicare); or

Option 2. Sole coverage provided under Medicare (under this Option, coverage under this Plan will terminate).

If the individual does not choose one of the above options in writing, this Plan will be primary (Option 1).

All Other Covered Persons Not in Active Service

For all other Covered Persons who are not in Active Service and who are eligible for Medicare benefits under this Plan will be coordinated with the dollar amount that Medicare will pay.

A Covered Person who is eligible for Medicare will be considered covered for all benefits available under Medicare (Part A and Part B), regardless of whether or not the person has actually applied for Medicare coverage.

Your Prescription Drug Coverage and Medicare

On January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. Your Employer has determined that their plan's prescription drug coverage, on average and for all plan participants, is expected to pay out as much as the standard Medicare prescription drug coverage. Each year, prescription drug coverage is available to everyone with Medicare through a Medicare authorized prescription drug plan. All Medicare authorized prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. People with Medicare will have the opportunity to enroll in a Medicare prescription drug plan annually between October 15th and December 7th of each year.

If you drop your Employer's coverage and enroll in a Medicare prescription drug plan, you may not be able to get your Employer's coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering

Medicare prescription drug coverage in your area.

In addition, your current Employer sponsored health coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare Part D prescription drug program and maintain your Employer's sponsored health coverage, you will still be eligible to receive all of your current health and prescription drug benefits.

You should also know that if you drop or lose your coverage with your Employer and don't enroll in Medicare prescription drug coverage after your Employer's coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go sixty-three (63) days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the next November to enroll.

Disability Due to End Stage Renal Disease

If a Covered Person becomes eligible for benefits under Medicare as a result of disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payer for the first thirty (30) months of disability. After the initial thirty (30) months, Medicare will be the primary payer.

Plans with One hundred (100) or More Employees Covered

If a Covered Person becomes eligible for benefits under Medicare, as a result of a disability (other than End Stage Renal Disease) and chooses to remain covered under this Plan, the benefits payable under this Plan will apply and this Plan will pay benefits first and Medicare will be the secondary payer.

For purposes of this provision, the term "disabled" will be the definition given by Social Security.

Special Enrollment Rights under CHIP

CHIP is an acronym for the Children's Health Insurance Program Reauthorization Act of 2009. This program extends and expands the Children's Health Insurance Program (CHIP).

If you are eligible for health coverage from your 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 you or your Dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an Employer-sponsored plan.

Once it is determined that you or your Dependents are eligible for premium assistance under Medicaid or CHIP, your Employer's health plan is required to permit you and your Dependents to enroll in the plan – as long as you and your Dependents are eligible, but not already enrolled in the Employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within sixty (60) days of being determined eligible for premium assistance**.

You may be eligible for assistance paying your Employer health plan premiums. You should contact your State for further information on eligibility –

GEORGIA – Medicaid - Website: **http://dch.georgia.gov/**
Click on Programs, then Medicaid - **Phone: 1-800-869-1150**

SOUTH CAROLINA – Medicaid – Website: **http://www.scdhhs.gov**
Click on "Getting Medicaid" and follow the drop-down menu. - Phone: 1-888-549-0820

For more information on special enrollment rights or to see other States, 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

Subrogation

Immediately upon payment of any benefits under this Plan, this Plan shall be subrogated to all rights of recovery against any person or organization whose course of conduct or action caused or contributed to the loss for which payment was made under this Plan.

The Covered Person and persons acting on his or her behalf shall do nothing to prejudice the Plan's subrogation rights and shall, when requested, provide the Plan with accident-related information and cooperate with the Plan in the enforcement of its subrogation rights.

The Covered Person acknowledges and agrees that this Plan's Subrogation rights are a first priority claim against any potentially liable party. This first priority claim is to be paid before any other claim for the Covered Person's general damages. The Covered Person agrees that this Plan shall be entitled to reimbursement even if the payments due to or received by a Covered Person from a third party are insufficient to compensate a Covered Person in part or whole for all damages sustained. For the purposes of this Subrogation provision, any recovery which does not specify the matters covered shall be deemed to include a recovery for all expenses incurred to the extent of any actual loss due to the disability involved.

Lastly pursuant to the rights of the Plan, the Covered Person acknowledges that this Plan specifically rejects the Common Fund Doctrine, the Made Whole Doctrine, and the Comparative Fault Doctrine. The Covered Person agrees that in the event the Covered Person hires counsel or obtains representation who performs a recovery action on behalf of the Covered Person to which this Plan may be entitled, that the fees, costs, and / or lien against any recovery initiated by that party are the sole responsibility of the Covered Person and shall not reduce this Plan's right of recovery in any amount. The Covered Person agrees that any attempt by a Covered Person or their counsel or representative to reduce, discount, circumvent, or otherwise infringe upon or eliminate in either whole or part of this Plan's right of recovery will constitute a violation of the terms of this Plan.

Rights of Recovery

In the event of any overpayment of benefits by this Plan, this Plan will have the right to recover the overpayment. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Covered Person will be requested to refund the overpayment. If the refund is not received from the Covered Person, recovery procedures will be initiated. Similarly, if payment is made on the behalf of a Covered Person to a Hospital, Physician, or other provider of health care, and that payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider.

ERISA Rights of Covered Employees

As a participant in this Plan, Covered Persons are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) as amended. ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Sponsor's office and at other specified locations, such as worksites or 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.
2. Obtain, upon written request to the Plan Sponsor, 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 Plan Sponsor may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report (if applicable). The Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal Court. In such a case, the court may require the Plan Sponsor to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Sponsor.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have questions about your Plan, you should contact the Plan Sponsor. If you have questions about this statement or about your rights under ERISA, contact the nearest office of the Employee Benefits Security Administration (EBSA) or U.S. Department of Labor, listed in a telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Plan Administration and ELAP

The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

Notwithstanding any provisions of this Plan Document and Summary Plan Description to the contrary, the Plan Sponsor has the authority to, and hereby does, allocate certain responsibility to ELAP Services, LLC ("ELAP"). The responsibility allocated to ELAP is limited to discretionary authority and decision-making authority with respect to any appeals of denied claims which are referred to ELAP by the Plan Administrator. The Plan Sponsor has allocated additional fiduciary responsibility to ELAP, limited to discretionary authority and decision-making authority with respect to the review and audit of certain claims in accordance with the applicable Plan provisions under the section, "Claim Review and Audit Program". Such claims selected as eligible for review and audit shall be identified by ELAP under guidelines to which the Plan Sponsor has agreed, and shall be referred to ELAP by the Plan Administrator. ELAP shall have no authority, responsibility or liability other than with respect to the Claim Review and Audit Program.

The Plan Administrator shall establish the policies, practices and procedures of this Plan. The Plan Administrator and ELAP shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator and ELAP shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise relative to a Plan participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator and/or ELAP as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator or ELAP decides, in its discretion, that the Plan participant is entitled to them.

Duties of the Plan Administrator
The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Plan participant's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third-party administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To establish and communicate procedures to determine whether a medical child support order or national medical support notice is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Duties of ELAP
ELAP shall have the following duties with respect to the Claim Review and Audit Program:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to benefits payable under the Plan and negotiating settlements, if appropriate;
6. To perform the duties in conjunction with the provisions of the Claim Review and Audit Program; and
7. To keep and maintain records pertaining to the Claim Review and Audit Program.

The duties of ELAP shall be limited to those set forth above

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief

Our Uses and Disclosures
We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll

provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on the prior page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.

- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual die.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official

- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Termination of the Plan

The Employer shall have the right, at any time, to terminate or amend this Plan. The Employer makes no promise to continue these benefits in the future and the right to future benefits will never vest. Upon termination, the rights of the Covered Persons to benefits are limited to claims incurred and due up to the date of termination.

Definitions

The following are definitions of the terms, which appear in the booklet:

Accidental Injury

Bodily Injury sustained by a Covered Person as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity, or any other cause) for care, which the Covered Person receives.

Active Service

A Covered Employee will be considered in Active Service:

1. On a day which is a scheduled work day if the Covered Employee is:
   a. Performing in the customary manner all of the regular duties of the occupation on a full-time basis either at the customary place of employment or at some location to which travel is required; or
   b. Absent solely by reason of vacation; or
2. On a day which is not a scheduled work day only if the Covered Employee was performing in the customary manner all of the regular duties of the occupation on the last preceding scheduled work day.

A Covered Dependent, other than a Newborn Child, will be considered in Active Service if on the day coverage would normally start, the Dependent is not confined for medical care or treatment (at home or elsewhere).

Allowable Claim Limits

The charges for services and supplies, listed and included as covered medical expenses under the Plan, which are medically necessary for the care and treatment of a covered illness or injury, but only to the extent that such fees are within the allowable claim limits. Please refer to the section, "Claim Review and Audit Program" for additional information regarding allowable claim limits.

Allowable Expense

Any Medically Necessary expense incurred by a Covered Person which is covered at least in part under this Plan.

Ambulatory Surgical Facility

A specialized facility:

1. Where licensing of such facility is mandated by law, has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing of such facility is not mandated by law, meets all of the following requirements:
   a. It is established, equipped and operated primarily for the purpose of performing surgical procedures;
   b. It is operated under the supervision of a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is devoting full-time to such supervision and

permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one Hospital in the area; and

c. It is other than a private office or clinic of one or more Physicians.

Annual Open Enrollment

The thirty (30) day period of time prior to the Plan Renewal Date in which all Eligible Employees may make changes to their coverage by adding or deleting coverage for themselves or their Dependents.

Calendar Year

The twelve (12) month period of January 1 through December 31 inclusive.

Chemical Dependency / Alcoholism

Physically and/or emotionally dependent on drugs, narcotics, alcohol or other addictive substances to a debilitating degree.

Close Relative

Any person that is immediately related to the insured (i.e. mother, father, brother, sister, spouse, or child) or directly related to the insured (i.e. aunt, uncle, grandparent, or cousin). Persons living in the insured's household such as domestic partners and/or significant others are also included.

Coinsurance

See *Plan Payment Provisions* Section.

Complications of Pregnancy

Conditions with diagnosis distinct from pregnancy, but which may be caused by or be adversely affected by pregnancy. Complications include but are not limited to the following:

- Acute Nephritis
- Nephrosis
- Cardiac decompensation
- Missed Abortion
- Pre-eclampsia
- Intrauterine fetal growth retardation
- Ectopic pregnancies

Convalescent Care Facility

May also be known as a Skilled Nursing Facility or Rehabilitative Center.

An institution, or a distinct part thereof, which is operated primarily for the purpose of providing inpatient Hospital, rehabilitative care, and treatment for individuals convalescing from an injury or illness, and:

1. is established and operated in accordance with applicable laws in the jurisdiction in accordance with applicable laws in the jurisdiction in which it is located or is licensed and/or approved by the regulatory authority having responsibility for licensing under

the law;
2. provides appropriate methods of dispensing and administering drugs and medicines; and
3. has transfer arrangements with one or more Hospitals.

It does not include institutions which provide only minimal care, Custodial Care, ambulatory or part-time care services or an institution which primarily provides treatment of Mental / Nervous Conditions, Chemical Dependency / Alcoholism or tuberculosis.

Covered Dependent

Any eligible Dependent whose coverage became effective and has not terminated.

Covered Employee

Any eligible Employee whose coverage became effective and has not terminated.

Custodial Care

Any room and board nursing services, and other institutional services that are primarily for daily living maintenance, even though the person is receiving medical services, when these services cannot reasonably be expected to substantially improve a medical condition.

Direct Agreement

A complete agreement between a Directly Contracted Provider and ELAP or the Plan Sponsor which contains the terms and conditions under which the Covered Person may access discounted fees and/or negotiated or scheduled reimbursement rates which the Plan adopts as Allowable Claims Limits for claims submitted by a directly contracted providers.

Directly Contracted Provider

A medical provider which has entered into a Direct Agreement with ELAP or the Plan Sponsor to provide certain medical services to Covered Persons at agreed upon Allowable Claim Limits.

Durable Medical Equipment

The least costly appropriate type of equipment prescribed by the attending Physician which:

1. is Medically Necessary;
2. is not primarily and customarily used for non-medical purposes (personal comfort, exercise or convenience);
3. is designed for prolonged use (with the exception of consumable supplies);
4. is for a specific therapeutic purpose in the treatment of an illness or injury;
5. is not classified as laboratory equipment (e.g. glucose Meters); and
6. would have been covered if provided in a Hospital.

Essential Health Benefit

Includes the following service categories:

- Ambulatory patient services
- Emergency services
- Hospitalization

- Laboratory services
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Pediatric services, including oral and vision care
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices

Experimental

Any treatment, procedure, facility, equipment, drugs, drug usage or supplies not yet recognized by this Plan and any such items requiring federal or other governmental agency approval not granted at the time services were rendered, or services and supplies which are not in accordance with generally accepted professional medical or dental standards or with the generally accepted methods of treatment.

Facility

A healthcare institution which meets all applicable state or local licensure requirements. For the purposes of the Claim Review and Audit Program, facility includes, but is not limited to, hospitals, emergency, rehabilitation and skilled nursing centers, ambulatory surgical facility, laboratories, X-ray, MRI or other CT facilities, and any other health care facility.

Fiduciary

The person or organization that has the authority to control and manage the operation and administration of the Plan. The Fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of this Plan. The named Fiduciary for this Plan is the Employer.

Genetic Counseling

A communication process between a specially trained health professional and a person concerned about the genetic risk of a disease. The person's family and personal history may be discussed, and counseling may lead to genetic testing.

Home Health Care

An agency or organization which provides a program of Home Health care and is established and operated in accordance with the applicable laws in the jurisdiction licensed and approved by the regulatory authority having responsibility for licensing under the law.

Hospice Care

A program of care which provides pain free and alert existence for the terminally ill patient during the last months of life, while actively including the family in the care. The program can accomplish the above through inpatient care or home care but emphasizes home care.

Hospital

An institution licensed as a hospital and accredited by the Joint Commission on the Accreditation of Hospitals, American Osteopathic Association or Commission of Rehabilitative

Facilities which:

1. is primarily engaged in providing acute care and treatment of Ill or Injured persons on an inpatient basis;
2. is under the supervision of one or more Physicians;
3. maintains twenty-four (24) hour nursing service; and
4. has organized facilities for laboratory and diagnostic work and major surgery.

However, an institution specializing in the care and treatment of Mental / Nervous Conditions, which would qualify as a Hospital, except that it lacks organized facilities on its premises for major surgery, shall nevertheless be deemed a Hospital.

"Hospital" shall also include a residential treatment facility specializing in the care and treatment of Chemical Dependency / Alcoholism, provided such facility is duly licensed if licensing is required by law in the jurisdiction where it is located, or otherwise lawfully operated if licensing is not required.

In NO EVENT, however, shall "Hospital" include an institution which is (other than incidentally) a rest home, a nursing home, or a home for the aged, place for Custodial Care, educational facility, home for the handicapped, or a rehabilitative facility unless such rehabilitation is specifically for treatment of a physical disability.

Illness

Bodily disorder, infection or disease and all related symptoms and recurrent conditions resulting from the same causes and including Complications of Pregnancy.

Injury

Physical harm sustained as the direct result of an accident, affected solely through external means and all related symptoms and recurrent conditions resulting from that same accident.

Intensive Care Unit

A section, ward or wing within the Hospital which is separated from other Hospital facilities, and:

1. is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;
2. has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and
3. provides room and board and constant observation and care by Registered Graduate Nurses (RN) or other specially trained Hospital personnel;

Excluding any Hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Late Enrollee

An individual who is enrolled for coverage after the initial eligibility date, described in “Eligibility Provisions.” Note, however, a Special Enrollee shall not be considered a Late Enrollee hereunder.

Medical Emergency

A severe Illness or Injury which:

1. Results in symptoms which occur suddenly and unexpectedly; and
2. Requires immediate Physician care to prevent death or serious impairment of the Covered Person's health.

Medically Necessary / Medical Necessity

Services and supplies which are determined by the Employer, or its authorized agent to:

1. Be appropriate and necessary for the symptoms and diagnosis and treatment of a medical condition;
2. Be in accordance with standards of good medical practice, within the organized medical community;
3. Not be solely for the convenience of the patient, Physician or other health care provider; and
4. Be the most appropriate supply or level of service, which can be safely provided.

For hospitalizations, this means that acute care as an inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's medical condition, and that safe and adequate medical care cannot be received as an outpatient or in a less intensified medical setting.

Just because the service is prescribed by a Physician does NOT mean the service is Medically Necessary. In an effort to make treatment convenient, to follow the wishes of the patient or the patient's family, to investigate the use of unproven treatment methods, or to comply with local Hospital practices, a Physician may suggest or permit a method of providing care that is not Medically Necessary.

Charges which are determined not to be Medically Necessary shall not be covered and no benefits will be payable for such charges. This will include, but is not limited to, services, which are determined in a retrospective review and audit not to have been Medically Necessary.

Medicare

Part A and Part B of the insurance program established by Title XVIII, United States Social Security Act, as amended, 42 U.S.C. Sections 1394, et seq.

Mental / Nervous Condition

This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality, or mood disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems and eating disorders such as anorexia and bulimia.

This is intended to include disorders, conditions and Illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.

Participating Employer

The Plan Sponsor and any Employer included in the "List of Participating Employers."

Physician

A licensed Doctor of Medicine (M.D.), Osteopathy (D.O.), Dentistry, Podiatry and Chiropractic providing a covered Service and acting within the scope of his/her license, who is not a member of the patient's immediate family.

Plan Sponsor

The person/organization responsible for the day-to-day functions and management of this Plan. The Plan Sponsor may employ persons or firms to process claims and perform other Plan connected services.

The Plan Sponsor is the named Plan Administrator within the meaning of Section 414(g) of the Internal Revenue Code of 1986, as amended, and is the named Administrator with the meaning of Section 3(16) (a) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Plan Year

The twelve (12) consecutive month period beginning on the Plan effective date and renewing on the same date each subsequent year.

Reasonable Charges

The most frequent charges which an individual Physician and Facility charges to the majority of patients for a given procedure. These charges must be within the range of fees charged by most Physicians and Facilities of similar training and experience in a given geographical area for this same procedure, with consideration given to unusual circumstances involving medical complications requiring additional time, skill and experience.

For Claim determinations made in accordance with the Claim Review and Audit Program, the Reasonable Charges will be the Allowable Claim Limits. Please refer to the section, “Claim Review and Audit Program,” for the definition of Allowable Claim Limits.

Special Enrollee

An Eligible Employee or an Eligible Dependent who refused coverage at the time it was originally offered because he or she had other Coverage, but whose other Coverage has terminated due to exhausting COBRA Coverage or by losing eligibility due to certain specified reasons (e.g., divorce, death). In addition, a Special Enrollee includes new Dependents due to birth, adoption or marriage.

Special Enrollment Period

The thirty (31) day period of time surrounding a loss of other Coverage for a Special Enrollee, or the thirty (31) day period of time after a Dependent is acquired due to birth, adoption or marriage, during which a Special Enrollee may request Coverage under this Plan.

Temporomandibular Joint Dysfunction

Manipulation of the joint or correction of occlusion by orthodontic treatment.

Third Party Administrator

The person/organization hired by the Plan sponsor in connection with the operation of this Plan and performing such functions, as processing and payment of claims, as may be delegated to it.

The Third-Party Administrator is:
Core Management Resources Group
PO Box 90
Macon, GA 31202-0090
478-741-3521 or 888-741-CORE

This Plan / Plan

The Plan of benefits as contained in the Summary Plan Description and Group Provision Pages, and any agreements, schedules and amendments endorsed by the Employer, Participating Employer or Plan Sponsor.

Total Disability or Totally Disabled

A Covered Employee will be considered Totally Disabled during any period when the Employee is completely unable to perform the duties of the Employee's occupation or work at any other gainful occupation. This definition is intended to correspond with Social Security's definition of Total Disability.

A Covered Dependent will be considered Totally Disabled during any period when, as a result of Injury or Illness, the Dependent is confined as a bed patient in a hospital and is completely unable to engage in the normal activities of a person of the same age and gender.