EMPLOYEE HEALTH CARE PLAN

Summary Plan Description

For coverage effective January 1, 2016

Health Insurance
Table of Contents

EMPLOYEE HEALTH CARE PLAN
OF
DODGE COUNTY HOSPITAL

ARTICLE I

Adoption Agreement and Elections

Section 1.01 The undersigned Employer hereby makes the elections below and adopts this Employee Health Care Plan for the benefit of Employees of the Employer. This Plan is intended to qualify as an Employees' health care plan and a group health plan under Sections 105 and 162 of the Internal Revenue Code of 1986 ("Code"), as amended, and the Regulations thereunder.

Section 1.02 Effective Date: The terms and conditions of this Plan shall be effective on and after January 1, 2016.

Section 1.03 Election Regarding Preferred Provider Agreement.

__x__ The Employer has entered into one or more Preferred Provider Agreements which are attached hereto to obtain discounts for medical supplies and services provided.

_____ The Employer has NOT entered into a Preferred Provider Agreement.

Participating Preferred Providers (hereinafter referred to as "Preferred Provider Organization" or "PPO") for this plan are:

1. Dodge County Hospital Network
2. First Health Network

Signature _____

Title _____ Date _____

Health Insurance Summary Plan Description

Name of Plan:	Dodge County Hospital Employee Health Plan
Type of Plan:	Self-Insured Welfare Plan providing health and prescription benefits.
Type of Administration:	Contract Administration with the Third Party Administrator.
Address of the Plan:	901 Griffin Ave Eastman, GA 31023-6720
Plan Number:	100903B
Group Number:	502
Plan Sponsor:	Dodge County Hospital
Federal Tax ID#:	58-0625140
Plan Effective Date:	October 1, 2011
Plan Renewal Date:	January 1st
Plan Fiscal Year Ends:	December 31st
Third Party Administrator:	Core Administrative Services, Inc. (CAS) P.O. Box 90 Macon, GA 31202-0090 (478) 741-3521 (888) 741-2673
Named Fiduciary:	Dodge County Hospital
Agent for Service of Legal Process:	Dodge County Hospital
Waiting Period:	60 days after date of hire, plus the first of the next month, unless waived by the Employer's President and CEO.
Effective Date of Coverage:	Coverage is effective on the first of the month following 60 days waiting period, unless waived by the Employer's President and CEO.
Termination Date of Coverage:	The day of the month termination is effective.
Contributions:	Both Employer and Employee contribute towards coverage.

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.[1]

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 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, except as provided by the outpatient dialysis provision, 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.

Medical Schedule of Benefits

Benefit levels applicable to eligible procedures, charges and prescriptions as set forth in Plan Payment Provisions and Prescription Drug Card Benefits Copayment sections.

Accident Expense *

1. Treatment must be obtained within ninety (90) days of accident;
2. The first $500 is paid at 100%, *waiving the deductible;
3. Charges incurred for Accident Expenses in excess of $500 are subject to deductible and payable at applicable coinsurance levels both In-Network and Out-of-Network.

Air Ambulance

Payable at 60% coinsurance for both In-Network and Out-of-Network, once the Deductible has been met. *The cap limits of allowable charges under this plan are set by a reasonable fee determined by Core Management Resource.*

Calendar Year Deductible

Applies to all covered expenses unless otherwise specified:

	In-Network	Out-of-Network
Individual	$2,000	$3,000

The Individual deductible applies to Employee and Spouse. Each Dependent child age 26 and under will have a $750 deductible for In-Network and $1,750 deductible for Out-of-Network.

Refer to *LifeStyles – Health Incentive Program* section on Page 13 for details about earning credit(s) to apply to the deductible.

Calendar Year Maximum Benefit

Unlimited per calendar year

Calendar Year Out-of-Pocket Maximum – (Includes deductible, coinsurances and copayments for medical and prescription benefits) *Non-covered items are excluded.*

	In-Network	Out-of-Network
	Medical	Medical
Individual	$6,600	Unlimited
Family	$13,200	Unlimited

Amounts satisfied toward the in-network, out-of-pocket limit will also be applied toward the out-of-network, out-of-pocket limit.

Chemical Dependency / Alcoholism

Inpatient: Payable as any other benefit
Outpatient: Payable as any other benefit

Chiropractic Care / Spinal Manipulation Treatment

Calendar Year Maximum is 20 visits.
In-Network – payable at 100% after a $35 co-pay.
Out-of-Network –payable at 60%, after the Deductible has been met.

Coinsurance

The Coinsurance for This Plan is as follows:
DCH Facility and Providers – 100%
In-Network – 75%
Out-of-Network – 60%

Convalescent Care / Skilled Nursing Facility

Maximum thirty (30) days per Calendar Year. (Additional days must be approved by the Medical Director prior to the 30 days expiring.)

Not to exceed the cost of a semi-private room in the facility. Confinement in a legally qualified Convalescent Care Facility.

Refer to *Plan Payment Provisions* for detailed covered expenses.

Dialysis Treatment – Outpatient (In-Network and Out-of-Network)

100% of the Reasonable Charge after all applicable deductibles and coinsurance

Please refer to Dialysis Treatment Outpatient Description

Emergency Room Services

Treatment for services rendered in a Hospital Emergency Room.

Emergency Room copayment (per visit) is $150, then payable at 75% coinsurance for both In-Network and Out-of-Network facilities. Copayment is waived if:

- an accident,
- admitted within twenty-four (24) hours, or
- true emergency per HCPCS/CPT E&M code levels 4 or 5.

Non-Accident, Non-Emergency related expenses are subject to the deductibles and applicable coinsurance.

For Accident Related Services see *Accident Expense.*
See also *Urgent Care Facility* under Plan Payment Provisions section.

Eye Exam

In-Network – $100 calendar year maximum
Out-of-Network – Not covered

Home Health Care

Refer to *Plan Payment Provisions* for detailed covered expenses.

Hospice Care

Refer to *Plan Payment Provisions* for detailed covered expenses.

Hospital-based Physician Charges

Anesthesiologists, Radiologists & Pathologists
In-Network – Payable at 75% coinsurance, after the Deductible has been met
Out-of-Network – payable 60%, after the Deductible has been met.

Hospital Services – *Pre-certification required*

Penalty for failure of pre-certification is $1,000.

Hospital "per admission" deductible:
In-Network – $500
Out-of-Network – $1,000

In-Patient Room & Board Rates

Semi-Private Room	Reasonable charges
Private Room	Most common Semi-Private
ICU or CCU	Reasonable charges
Miscellaneous Services	Reasonable charges

In the event a hospital does not contain semi-private rooms, the private room limit is 90% of the hospitals lowest priced private room. If a private room or isolation room is medically necessary due to contagious disease, the hospital's reasonable charge for such room will be a covered expense.

LifeStyles – Health Incentive Program

Participation in the LifeStyles Health Incentive Program is voluntary. A Health Risk Assessment (HRA) is required in order for employees and their spouses to qualify for incentive credits. These incentives are specific to your medical plan – and are not cash awards. The earned credits apply to the individual deductible.

Refer to *LifeStyles – Health Incentive Program* section for details about earning credit(s) to apply to the deductible.

Lifetime Maximum Benefit

There is no Lifetime Maximum on Essential Health Benefits.
For Lifetime Maximum on non-essential health benefits, see specific treatment, therapy or program.

Maternity Expenses

Maternity Benefits are available for all Covered Female Participants. NO maternity coverage for Dependent Children.
Routine Nursery Care is included as an expense of the baby.

Mental / Nervous Conditions

Inpatient: Payable as any other benefit
Outpatient: Payable as any other benefit

Network

The primary network for this Plan is: Dodge County Hospital Network (DCHN)

The DCHN includes the following listed Hospitals:

- Medical Center of Central Georgia (MCCG)
- Coliseum Medical Center/Coliseum Northside/Coliseum Same Day Surgery Center
- Fairview Park Hospital
- Meadows Regional Medical Center (MRMC)

Non-Accident, Non-Emergency related services are covered at the above listed Hospitals only if the patient is referred by a DCHN doctor.

For emergencies and services not available at these Hospitals, hospital services will be considered at the in-network level of benefits only if pre-approved by Core Management Resources Group (must call for approval within forty-eight (48) hours of an emergency admission). The First Health Network will be used as a secondary network for emergencies, when travelling outside of the primary network area, and for Doctors.

The following hospitals are excluded, except in a case of an emergency or waived by Dodge County Hospital's President and/ or CEO:

- *Taylor Regional Hospital*
- *Lower Oconee Community Hospital*
- *Doctors Hospital – Tattnall*
- *Bleckley Memorial Hospital*
- *Women's Surgery Center in Statesboro*

OB/GYN Visit

Plan pays 75% after $35 copayment whether in-network or out-of-network

Physician / Specialist Copayment

In-Network – $35 copayment then balance of eligible expenses at 75%.
Out-of-Network – Eligible expenses subject to individual deductible then payable at 60% coinsurance level, office copayment NOT applicable.

Prescription Drug Copayment

There is not an additional deductible for prescription drugs. Refer to Patient First Prescription Drug Expense Benefits and Prescription Drug Coverage Provisions for detailed covered expenses.

Copayments are the greater of the flat dollar or percentage copayment:

Per Prescription	**RETAIL** (Maximum 30 Days)	**MAIL ORDER** (60 or 90 Days)
Generic	$10 or 25% cost of drug	$20 or 25% cost of drug after $150
Preferred Brand	$30 or 30% cost of drug	$60 or 30% cost of drug after $150
Non-Preferred Brand	30% cost of drug under $150 50% cost of drug $150 and over	30% cost of drug under $150 50% cost of drug $150 and over

Routine Physical Exams

In-Network – Eligible expenses will be paid at 100%; not subject to copayment or annual deductible.

Out-of-Network – Not covered.

Immunizations required solely for foreign travel are NOT covered.
Refer to *Routine Physical Exams* under Plan Payment Provisions section.

Temporomandibular Joint Dysfunction

Refer to *Plan Payment Provisions* for detailed covered expenses.

Well Baby Care

Physician's fees for routine care, examination or immunizations.
For Children over one year of age, refer to *Routine Physical Exams*.
Refer to *Well Baby Care* under Plan Payment Provisions section and covered preventive services for children on page 33.

X-Ray / Lab Test

Performed at:	**In-Network**	**Out-of-Network**
Doctor's Office	Deductible/75%	Deductible/60%
Hospital or Free-standing Facility	Deductible/75%	Deductible/60%

LifeStyles – Health Incentive Program

The LifeStyles program focuses on five defined health benchmarks: body mass index (BMI), blood pressure, cholesterol, diabetes management, and non-nicotine use. All five of the chosen categories, if unmanaged, may result in dramatic health issues and extensive health costs.

Health Incentive Program details

Employees and their spouses may elect to take a voluntary health risk assessment (HRA) to see if they meet specific health benchmarks:

- Blood Pressure Reading: ≤ 140/90
- Cholesterol: ≤ 200
- Body Mass Index (BMI): ≤ 30.0
- Triglyceride: ≤ 150
- Diabetic Management: Compliant in below category
  - Type I diabetic Hemoglobin A1c (HbA1c) ≤ 7.6
  - Type II diabetic Hemoglobin A1c (HbA1c) ≤ 7.0
  - Non-diabetic Hemoglobin A1c (HbA1c) ≤ 6.0

Health Plan Deductible Credits

Health Plan Deductible Credits are available to employees and their spouses covered under the plan. For each benchmark met, a $250 credit will be applied to their individual deductible, giving each individual the potential to earn up to $1,250 in credits to reduce their deductible.

If an employee and/or spouse are genetically (or otherwise) predisposed and they minimize their risk by taking prescribed medications that bring their test results to desired levels, they can still be awarded the health incentive credit(s).

An employee and their spouse may have different deductibles based on the credits each can earn. Dependent children age 26 and under (on the plan's effective date) will automatically have their deductible lowered to the $750 In-Network minimum.

Each plan year consists of a window of opportunity to complete the HRA. If the employee and their spouse neglects to complete the HRA within the allotted time **(see Health Risk Assessment details)** they will be ineligible for the deductible credit(s) for the remaining plan year and will have to wait until the next plan year to re-quality. However, if an employee and their spouse did complete their HRA within the allotted time and they were unable to meet a specific parameter, they are eligible for a second chance alternative standard **(see Second Chance Alternative Standard).**

If all Health Incentive credits applied, deductible can be as low as:

Individual	$750

Health Risk Assessment details

HRAs are conducted each plan year during an eligibility period for members with a January 1st effective date (the dates to be communicated by DCH Human Resources). Anyone who is added to the plan mid-year (after the January 1st plan effective date – e.g., new hire, addition of dependent, etc.) must complete the HRA within ninety (90) days of addition to the Plan.

HRAs are performed by the Core nurse at Dodge County Hospital. **It is the participants' responsibility to contact the Core Management Resources Nurse, to schedule their assessment. Please call 478-741-3521 to schedule your assessment appointment.**

The HRA will consist of:

1. Assessment of height, weight, blood pressure
2. Personal Health Survey
3. Blood Work (Hemoglobin A1c and Lipid Panel)

This is a fasting assessment; therefore, do not eat or drink anything after midnight before having the assessment performed. However, if you are taking medication for blood pressure or diabetes on a regular basis, it is permissible to take your medication with a sip of water.

Second Chance Alternative Standard: If any employee or spouse is unable to meet a specific parameter, they are eligible for a Second Chance alternative standard. The alternative will be to meet the specific parameter by June 30, 2016. For example, if you fail a credit for a healthy blood pressure, you will have an opportunity to reach a healthy blood pressure between your original HRA and June 30, 2016. The alternative standard for BMI will be a 5% reduction in body weight.

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 Fees for services rendered out-of-network or when no network is in place, once the deductible has been met, unless otherwise marked by an asterisk (*) which means the deductible is waived.

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 Plan.

Injuries sustained as the direct result of a non-occupational accident.

1. Treatment must be obtained within ninety (90) days of accident;
2. The first $500 is paid at 100%, waiving the deductible;
3. Charges incurred for Accident Expenses in excess of $500 are subject to deductible and payable at applicable coinsurance levels both In-Network and Out-of-Network.

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*.

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 NOT 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 #12 under “General Limitations and Exclusions – Medical.”

Assistant Surgeon

This is a covered expense under this Plan.

Not to exceed 20% of reasonable charges for Surgeon’s fees.

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 NOT 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.

See also *LifeStyles – Health Incentive Program* page 13.

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

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. Maximum per plan is 20 visits.

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 preventative 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 all of the 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

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.

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 (30) days per Calendar Year. (Additional days must be approved by the Medical Director prior to the 30 days expiring.)

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

1. Begins within seven (7) days following an eligible Hospital confinement of at least five (5) days duration;
2. Is prescribed by a Physician who remains in attendance at least once every seven (7) days;
3. Is for necessary recuperative care of the same condition requiring the prior hospitalization;
4. 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 pre-approval 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*.

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*.

Dental Care

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.

Diagnostic Services

This is a covered expense under this Plan.

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

Dialysis Treatment - Outpatient

This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

A. Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:

(1) the concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services,

(2) the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,

(3) evidence of (i) significant inflation of the prices charged to Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and

(4) the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.

B. Dialysis Program Components. The components of the Dialysis Program are as follows:

(1) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

(2) Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after January 1, 2011, regardless when the expenses

related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.

(3) Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:

i. Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

ii. Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

(4) In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:

i. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

ii. Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan Administrator's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

iii. Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and

Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

iv. Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

v. Additional Information related to Value of Dialysis-Related Services and Supplies. The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

vi. All charges must be billed by a provider in accordance with generally accepted industry standards.

5. Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

6. Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

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.

Emergency Room copayment (per visit) is $150, then payable at 75% coinsurance for both In-Network and Out-of-Network facilities. Copayment is waived if:

- an accident,
- admitted within twenty-four (24) hours, or
- true emergency per HCPCS/CPT E&M code levels 4 or 5.

Non-Accident, Non-Emergency related expenses are subject to the deductibles and applicable coinsurance.

For Accident Related Services see *Accident Expense.*
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 the 90th percentile for reasonable charges.

Charges in excess of the above percentile 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

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

When travel outside the United States is for the purpose of obtaining medical treatment, Charges and Services received are NOT Covered Expenses under This Plan.

When temporarily traveling 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.

Gastric Bypass

This is NOT a Covered Expense under This Plan.

Charges leading to or in connection with Gastric Bypass.

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.

Genetic Testing is only covered under the Plan if the following conditions are met:

Routine Preventive Services

1. Testing must be Pre-certified by Core Health Services (CHS).
2. Member must be determined to be at high risk with a family history that is associated with the deleterious mutations in the BRAC1 or BRAC2 genes.

3. Member must be referred to a certified genetic counselor for genetic counseling to determine if BRAC testing is appropriate.

Non-Routine Preventive Services

1. Testing must be Pre-certified by Core Health Services (CHS).
2. The testing results will be used to determine the course of treatment for an existing condition.

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.

Hearing Aids

This is NOT a Covered Expense under This Plan.

An electronic amplifying device designed to bring sound more effectively in the ear.

Hearing Exams

This is NOT a Covered Expense under This Plan.

Examinations to evaluate hearing quality or loss by a licensed Physician or Facility.

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 twenty (120) 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.

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

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

Learning Disorders

This is NOT a Covered Expense under This Plan.

Testing services in connection with Learning Disorders; including such disorders as Attention Deficit Disorder and Dyslexia.

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) [2]

This is a covered expense under this Plan.

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.

Maternity Benefits are available for the Covered Employee or Covered Spouse Only. Covered Dependent Children have no Maternity benefits. 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 forty-eight (48) hours (or ninety-six (96) hours as applicable.) However, This Plan recommends Pre-Notifying CHS during the first trimester of a Maternity Diagnosis and again within forty-eight (48) hours of delivery of the baby.

Any hospital stays longer than forty-eight (48) hours (or ninety-six (96) hours as applicable),

must be Pre-Certified, and will be subject to the Pre-Certification penalties as defined in *Pre-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.[3]

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

The Primary Network for this Plan is the Dodge County Hospital Network (DCHN) consisting of the following hospitals: Dodge County Hospital (DCH), the Medical Center of Central Georgia (MCCG), and Coliseum Medical Center/Coliseum Northside/Coliseum Same Day Surgery Center and Fairview Park Hospital. Services are only covered at these hospitals if the patient is referred by a DCHN doctor. The First Health Network will be used as a secondary network for emergencies, when travelling outside of the primary network area, and for OB/GYN Doctors.

For emergencies and services not available at these Hospitals, hospital services will be considered at the in-network level of benefits only if pre-approved by Core Management Resources Group (must call for approval within forty-eight (48) hours of an emergency admission).

Network refers to those hospitals and physicians, which This Plan has contracted with in order to obtain certain discounted fees. Each Covered Person under This Plan is directed to use these Network providers by having different Reimbursement Rates for going In-Network versus Out-of-Network. See the Medical Schedule of Benefits for the applicable Reimbursement Rates. A complete list of providers within the Network may be obtained from CAS at no charge or you may search with CoreLink at www.corehealthbenefits.com.

All referrals for radiology, anesthesia, or pathology made by an In-Network Physician will be reimbursed at In-Network percentages. Specialists, other than those mentioned previously, must be a part of the Network in order to receive reimbursement In-Network. It is the member's responsibility to assure that their provider is in the Plan's Network. Out-of-Network providers will only be considered eligible for the in-network level of benefits in emergency situations or when approved by the Third Party Administrator.

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 Program.
Pre-certification is required. To obtain the highest level of benefits, the Member or Provider must obtain pre-certification.

Covered Services include only the following:

- Fracture or 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;
- Treatment of Temporomandibular Joint Syndomre (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered services do not included 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.

Osteoporosis

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 for this Plan is $35 per In-Network office visit, not per service. For Out-of-Network Physician/Specialist, payable at 60% coinsurance once the Deductible has been met.

A flat amount that a Covered Person pays at the time of the office visit. After the copayment, charges are covered at 75% (100% when performed by DCH Network Physician). Once the Calendar Year Out-of-Pocket Maximum has been reached, the copayment amount will no longer apply.

Physician Charges, Certain

This is NOT a Covered Expense under This Plan.

Charges for telephone consultations, failure to keep scheduled appointments, completion of claim forms or providing medical information necessary to determine coverage.

Pre-Admission Testing

This is a covered expense under this Plan.

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

Pre-Existing Conditions [4]

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.

Pre-Marital Exams

This is NOT a Covered Expense under This Plan.

Blood testing for the purpose of obtaining a Marriage License.

Preventive Care [5]

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
- Hepatitis B screening for nonpregnant 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

Covered Preventive Services for Women, Including Pregnant Women

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screenings every 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
- 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 Immundefiency Virus (HIV) screening and counseling for sexually active women
- Human Papillomarvirus (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
- 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
- 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 http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

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 pre-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 Plan.
Pre-Certification 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.

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.

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.*

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 *Pre-Certification and Concurrent Review*.

Self-Inflicted Injuries

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 *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.

Therapy

This is a covered expense under this Plan. Precertification required for Pulmonary Rehabilitation and Speech Therapy.

Biofeedback, Recreational or Educational

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.

Limited to Twenty-Five (25) visits per year.

Physical

This is a covered expense under this Plan.

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.

Limited to Twenty-Five (25) visits per year.

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.

Limited to Twenty-Five (25) visits per year.

See also *Exclusions*.

Transplant

Non-Human to Human

This is a covered expense under this Plan.

Any non-experimental or non-investigative Animal Organ or Tissue, Artificial or mechanical transplants and surgical or medical care related to such procedures.

Organ

This is a covered expense under this Plan.

The following expenses will be eligible, but are limited to the expenses shown below:

1. Organ and tissue procurement consisting of removing, preserving and transporting the donated part, including the surgical replacement procedure when:
    a. Both the recipient and the donor are Covered by This Plan, they will not have a separate limit other than the Lifetime Maximum Benefit, and both recipient and donor charges will apply toward the recipient's Lifetime Maximum Benefit;
    b. Only the recipient is Covered by This Plan, benefits are provided for services for both the recipient and donor, provided benefits to the donor are not furnished under some other form of surgical-medical coverage;

c. The recipient is NOT Covered by This Plan and the donor is Covered by This Plan, expenses will NOT be covered for either the recipient or the donor.

2. Transportation, Lodging and meals costs – LIMITED TO A $10,000 MAXIMUM PER TRANSPLANT. Covered expenses include the following:
   a. Reimbursement for transportation of the recipient and a companion ($0.32 per mile) to and from the site of the Transplant. If the recipient is a minor, transportation of two (2) persons who travel with the minor will be allowed;
   b. Lodging and meal costs incurred in the interim by such companion(s) during the hospital confinement period up to $200 per day per person.
   c. If the recipient is required to remain in the vicinity of the hospital for a period of time following the transplant for follow up care and the recipient cannot be transported from home due to distance, expenses for lodging and meals will be allowed for the recipient and a companion up to $200 per day per person.
   d. All above outlined expenses are subject to the $10,000 maximum per transplant.

Medically Necessary organ or tissue transplant procedures which are not experimental or not investigational and all related Covered Expenses when incurred by a Covered Person who is the recipient of such transplant.

Transsexual Surgery

This is NOT a Covered Expense under This Plan.

Charges leading to or in connection with Transsexual Surgery.

See also #14 under "General Limitations and Exclusions – Medical."

Urgent Care Facility

This is a covered expense under this Plan.

Use of these types of facilities is considered the same as using a Hospital Emergency Room.

For Accident Related Services see *Accident Expense*.

Non-Accident Services charges are subject to the Deductible and applicable Coinsurance. There are no Copays for this type of facility.

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).

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 *Routine Physical Exams*.

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. Charges made for treatment, services, or supplies not included in the Eligible Expenses under any supplemental Accident Expense Benefits section or the Room and Board, Surgical and Medical Expense Benefits section;
2. 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;
3. Charges incurred in connection with eye refractions or the purchase or fitting of eyeglasses or hearing aids; charges for radial keratotomy;
4. 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;
5. 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;
6. Charges, incurred for services or supplies, which constitute personal comfort or beautification and are chosen by the Covered Person;
7. Surgical correction (e.g. gastroplasty, Gastric Bypass, or non-medical treatment of obesity, (e.g. dietary or exercise counseling for weight control, etc.)).
8. 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;
9. Charges that would not have been made if no coverage existed or charges that a Covered Person is not required to pay;
10. 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;
11. 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.)
12. 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;
13. Charges for or related to sex change surgery 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;
14. 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;
15. Any portion of an expense, charge, or fee that exceeds the Reasonable expense;

16. Charges for Experimental or Investigational Services. 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;
19. Charges for air conditioners, dehumidifiers and humidifiers, air purifiers, heating pads, hot water bottles, home enema equipment, and similar equipment and supplies; charges for electrical power, water and disposal systems, baths and pools or their installation (orthotics are limited to the initial pair);
20. Charges for services related to obtaining or implanting a non-human, artificial, or mechanical organ;
21. Charges for the reversals of sterilization procedures;
22. 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
23. Charges for physical therapy unless ordered by a Physician to restore prior function;
24. Charges for special education and/or learning disorders;
25. Dental treatment, except as relates to accidental injuries outlined elsewhere in this document, or if Dental Benefits are a component of this Plan;
26. Osteotomy, orthognathic surgery, or maxilla-facial or dental facial orthopedics;
27. Any day of Hospital confinement as an Inpatient or Outpatient for dental surgery 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.
28. Telephone consultations;

29. 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.
30. Care and treatment for hair loss.

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.

Comprehensive Dental 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.

If the aggregate charges of dentists and/or doctors for a proposed course of treatment of a Covered Person may be reasonably expected to total $200 or more, a Pre-determination of Benefits (defined below) is recommended but not required by you from Core Administrative Services. 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 Dental Schedule of 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.

Dental Schedule of Benefits

Covered Types of Dental Care:

Type A: Diagnostic and Preventive
Type B: Basic Procedures
Type C: Major Procedures
Type D: Orthodontia Procedures (*Optional Coverage*)

Calendar Year Deductible

$50 per Calendar Year per covered individual ($150 per Family) for Types B & C procedures only. Waived for Diagnostic and Preventive services.

Calendar Year Maximum per Person

The Calendar Year Maximum Benefit is $1,000 per covered individual.

Lifetime Maximum per Person for Orthodontic Services (Optional Coverage)

The Lifetime Maximum Benefit is $1,200 per covered dependent child under the age of nineteen (19).

Coinsurance

The Calendar Year Coinsurance for This Plan is as follows:
Type A: 100% of Usual and Customary
Type B: 80% of Usual and Customary
Type C: 50% of Usual and Customary

Eligibility is based on the same eligibility requirements as for the Medical portion of the Plan.

Optional Orthodontia

Type D: Payable at 50% to a maximum benefit of $1,200, not to exceed $600 in annual benefits

Waiting Period for Late Enrollees

Type A and B services are covered once coverage is in force. Type C Services have either a twelve (12) or a twenty four (24) month waiting period, depending upon the type procedure. Type D services have a twelve (12) month waiting period.

Benefits from Other Sources

For instance, you may be covered by this plan and a similar plan through your Spouse's Employer. If you are, we coordinate our benefits with the benefits from the other plans. We do this so no one gets more in benefits than the charges incurred. Read **"**Coordination of Benefits" for details.

Plan Payment Provisions – Dental

PRE-TREATMENT DETERMINATION

It is required that a Dental Treatment Plan be filed before treatment begins when charges for a period of dental treatment (other than emergency treatment) are expected to exceed $200. The phone number for pre-authorization is 1-888-741-2673.

COVERED CHARGES

Covered charges will be the actual cost charged to you or your Dependent for treatment or service, but not more than the prevailing charge. Also:

- If it is determined that more than one procedure could be performed to correct a dental condition, covered charges will be limited to the maximum allowance for the least expensive of the procedures that would provide professionally acceptable results.
- Covered charges will include only those charges for treatment or services that begin (as defined in the following provision) while you and your Dependents are covered under this Plan.
- Covered charges will include only those charges for treatment or service that is completed while you and your Dependents are covered under the Plan.

The following is a complete list of Covered Dental Procedures under this Dental Expense Benefit. Any procedure not listed is excluded.

TYPE A – Diagnostic and Preventive

- EXAMINATIONS – Oral Examination - Only one oral examination (other than emergency examination) will be covered in each six (6) month period.
- RADIOGRAPHS
  - Intraoral X-Rays
    - Complete Series - Covered once each three (3) year period
    - Bitewing - Only two (2) will be covered in a calendar year
    - Occlusal
    - Periapical
  - Extraoral X-Rays - Only one (1) of the listed extraoral procedures will be covered twice in a calendar year
    - Panoramic
    - Sialography
    - TMJ
    - Cephalometric film
    - Posteroanterior and lateral skull and facial bone survey
  - Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Class I covered charges
- PREVENTIVE SERVICES
  - Prophylaxis (Cleaning of teeth, including scaling and polishing) - Covered twice in a

calendar year
    - Topical application of fluoride (including prophylaxis) - Applicable only to Dependent Children. Only one application will be covered each calendar year- Applicable only to children under age fourteen (14)
    - Space maintainers - Applicable only to children under age fourteen (14)
    - Topical application of sealers - Applicable only to children under age fourteen (14) - Covered once each quadrant in each four (4) year period
- OTHER SERVICES
    - Biopsy of oral tissue
    - Palliative treatment - Covered as a separate procedure only if no other service (except x-rays) is provided during the visit
    - Bacteriologic culture
    - Histopathologic examination
    - Pulp vitality test
    - Diagnostic test - Covered once each two (2) year period

TYPE B – Basic Procedures

- RESTORATIONS
    - Fillings (Amalgam, silicate, plastic or composite, including pin retention when necessary)
    - Stainless steel crown
- ORAL SURGERY
    - Extraction of non-impacted teeth
    - Alveoplasty
    - Removal of dental cysts and tumors
    - Surgical incision and drainage of dental abscesses
    - Other surgical procedures
    - Tooth replantation
    - Surgical exposure to aid eruption
    - Surgical repositioning of teeth
    - Excision of hyperplastic teeth
- PERIODONTIC SERVICES
    - Surgical procedures - Only one (1) of the listed surgical procedures is covered for each quadrant per calendar year
        - Gingivectomy
        - Gingival curettage
        - Osseous surgery
        - Osseous graft
    - Scaling and root planting (full mouth) - Twice each quadrant in a calendar year
    - Periodontal appliance - One appliance each three (3) year period
    - Periodontal prophylaxis
- ENDODONTIC SERVICES
    - Pulp cap
    - Vital pulpotomy

- ♦ Root canal therapy, including treatment plan, diagnostic x-rays, clinical procedures and follow-up care
- ♦ Apexification
- ♦ Apicoectomy
- ♦ Retrograde filling
- ♦ Apicoectomy and retrograde filling covered as a separate procedure only if performed more than one (1) year after root canal therapy is complete
- ♦ Apical curettage
- ♦ Root resection
- ♦ Hemisection

- ANESTHESIA
  - ♦ General Anesthesia - Covered as a separate procedure only when required for complex oral surgical procedures covered under the Plan (and only when not performed in Hospital)
- OTHER SERVICES
  - ♦ Repairs to bridges and full or partial dentures
  - ♦ Adding tooth to partial denture
  - ♦ Relining full or partial dentures (upper or lower) - Covered only if relining is done more than one (1) year after the initial installation, and then not more than once each two (2) year period
  - ♦ Recementing inlay, crown, bridge, or space maintainer
  - ♦ Consultation with specialist
  - ♦ Antibiotic drug injection

TYPE C – Major Procedures

- RESTORATIONS (12 month waiting period for late enrollees)
  - ♦ Gold foil
  - ♦ Gold inlays and onlays
  - ♦ Gold restorations - Covered only if the tooth cannot be restored by a silver filling and, for replacements, at least five (5) years have elapsed since the date of the last placement
  - ♦ Porcelain inlay
  - ♦ Crowns (single restoration only)
    - ➢ Plastic (acrylic)
    - ➢ Plastic, prefabricated
    - ➢ Plastic with non-precious metal
    - ➢ Plastic with semi-precious metal
    - ➢ Plastic with gold
    - ➢ Porcelain with non-precious metal
    - ➢ Porcelain with semi-precious metal
    - ➢ Porcelain with gold
    - ➢ Gold (3/4 cast)
    - ➢ Gold (full cast)
    - ➢ Non-Precious metal (full cast)

- Semi-Precious metal (full cast)
- Crowns are covered only if the tooth cannot be restored by a filling and, for replacements, at least five (5) years have elapsed since the last placement. Crowns for the primary purpose of periodontal splinting, altering vertical dimensions or restoring occlusion are not covered.

♦ Cast post and core - Covered only for teeth that have had root canal therapy. Steel post and composite or amalgam

- PROSTHODONTICS, FIXED
  - ♦ Fixed bridges - Initial placement of fixed bridges to replace teeth which were missing prior to the effective date of the individual's coverage will be covered only after the individual has been covered under this Plan for twenty-four (24) consecutive months, unless the fixed bridgework also included replacement of a natural tooth extracted while covered. Replacement of fixed bridges is covered only if the original bridge cannot be made serviceable and (a) the individual has been covered under this Plan for at least twelve (12) consecutive months, and (b) five (5) years have elapsed since the last placement.
- PROSTHODONTICS, REMOVABLE
  - ♦ Full or partial dentures - Initial placement of full or partial removable dentures to replace teeth which were missing prior to the effective date of the individual's coverage will be covered only after the individual has been covered under this Plan for twenty-four (24) consecutive months, unless the denture also includes replacement of a natural tooth extracted while covered. Replacement of a full or partial removable denture will be covered only if the existing denture cannot be made serviceable and (a) the individual has been covered under this Plan for at least twelve (12) consecutive months (not applicable if replacement is made necessary by the initial placement of an opposing full denture), and (b) five (5) years have elapsed since the last placement. Covered charges do not include any additional charges for overdentures or for precision or semi-precision attachments.

TYPE D – Orthodontia Procedures (*OPTIONAL COVERAGE*)

If elected, eligible expenses under Orthodontic Services are those incurred for diagnosis, surgical therapy, and appliance therapy. This includes related oral exams, surgery and extractions. But these will be an eligible expense only if the insured Dependent child is under the age of nineteen (19) and the treatment is for:

- Overbite or overjet of at least four millimeters;
- Maxillary and mandibular arches in either protrusive or retrusive relation of at least one cusp;
- Cross-bite;
- An arch length difference of more than four millimeters in either the maxillary or mandibular arch; or
- Bimaxillary protrusion of 10 millimeters or more.

BEGINNING DATE OF TREATMENT

Treatment or service will be considered to begin:

- For root canal therapy, on the date pulp chamber is opened and the pulp canal explored to the apex;
- For crowns, fixed bridgework, inlays or onlays restoration, on the date the tooth or teeth are fully prepared;
- For full or partial dentures, on the date the master impression is made; and
- For all other, on the date the treatment or service is performed.

General Limitations and Exclusions – Dental

Except as specifically stated, no benefits will be payable under this Plan for:

1) **Analgesia** – Separate charges for pre-medication, local anesthesia, analgesia, or conscious sedation.
2) **Appliances** – Items intended for sport or home use, such as athletic mouth guards or habit-breaking appliances.
3) **Congenital or Development Conditions** – The treatment of congenital (hereditary) or developmental (following birth) malformations.
4) **Cosmetic Dentistry** – Treatment rendered for cosmetic purposes.
   NOTE: The maximum allowance for a necessary crown or pontic posterior to the second bicuspid will be the allowance for a gold crown or pontic. That is, facings on molar crowns will be considered cosmetic and will not be covered.
5) **Crowns** – Crowns placed for the purpose of periodontal splinting.
6) **Customized Prosthetics** – Precision or semi-precision attachments, overdentures, or customized prosthetics.
7) **Discoloration Treatment** – Any treatment to remove or lessen discoloration except in connection with endodontia.
8) **Excess Care** – Services, which exceed that necessary to achieve acceptable level of dental care. If the Plan Administrator determines that alternative treatment could be (could have been) provided for the least costly procedure (s) which would produce a professionally satisfactory result.
9) **Duplicate prosthetic devices or appliances** – Temporary crowns, temporary partials, temporary bridgework and temporary dentures.
10) **Excess Charges** – Charges in excess of the Reasonable charges for dental services or supplies.
11) **Experimental Procedures** – Services which are considered experimental or which are not approved by the American Dental Association.
12) **Grafting** – Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).
13) **Implants** – Implants (materials implanted into or on bone or soft tissue) or the removal of implants.
14) **Lost or Stolen Prosthetics or Appliances** – Replacement of a prosthetic or any other type of appliance which has been lost, misplaced, or stolen.
15) **Medical Plan Coverage** – Any dental services to the extent to which coverage is provided under the terms of the medical benefits sections of this Plan.
16) **Myofunctional Therapy** – Muscle training therapy or train to correct or control harmful habits.
17) **Non-Professional Care** – Services rendered by other than a dentist (D.D.S or D.M.D) or a dental hygienist or x-ray technician under the supervision of a dentist.
18) **Occlusal Restoration** – Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh) or change vertical dimension, except as outlined in Type D.
19) **Oral Hygiene Counseling** – Education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene instruction or plaque control. Charges for

supplies normally used at home, including but not limited to toothpaste, toothbrushes, water-piks, and mouthwashes.

20) **Orthognathic surgery.**
21) **Personalization or Characterization of Dentures.**
22) **Prescription Drugs** – Prescription drug coverage is provided only under the terms of the Medical portion of this Plan, if any.
23) **Prior to Effective Date** – Charges for courses of treatment which were begun prior to the Covered Person's effective date, including crowns, bridges or dentures which were ordered prior to the effective date.
24) **Prosthetics** – Initial placement of a prosthetic (i.e., a bridge, partial or full denture, including crowns or inlays used as abutments) for teeth extracted/lost prior to the effective date of coverage under this Plan or the prior plan of the Employer. Replacements will only be covered if the original is at least five years old and no longer serviceable or damaged in an accident while covered.
25) **Addition of teeth to partial dentures or fixed bridgework**, except for the replacement of teeth which are extracted while the person is covered under the Plan. Also, adjustment of prosthetic appliances within six (6) months of initial installation and not included in the cost of such appliance.
26) **Sealants** – Materials applied to the teeth to seal developmental imperfections, such as pits and fissures. (Covered up to age sixteen (16).)
27) **Service or Supply** not shown on the Schedule of Covered Procedures.
28) **Splinting** – Wiring or bonding teeth or crowns to act as a splint for any reason.
29) **Treatment or services:**
    a) for malignancies, cysts and neoplasm's.
    b) which you or your Dependent have no financial liability or that would be provided at no charge in the absence of coverage, or that is paid for or furnished by the United States Government or one of its agencies (except Medicaid).
    c) that results from war or act of war, or from voluntary participation in criminal activities.
    d) incurred for any condition for which a Covered Person is eligible for coverage or benefits under Workers' Compensation, Occupational Disease law, or similar law.
30) **Temporomandibular Joint Dysfunction / Maxillofacial Surgery** – Any charges for jaw (mandibular) augmentation or reduction procedures; or procedures, restorations or appliances for the treatment or for the prevention of Temporomandibular Joint Dysfunction Syndrome, including the correction of abnormal positioning and relationship of teeth. **(See also Medical Plan section)**

NOTE:
No benefits will be payable for a prosthetic where the impression(s) was taken during the last thirty (30) days of eligibility. In addition, no benefits will be payable for prosthetics that are placed after the termination date of coverage, regardless of when the impression was taken.

Prescription Drug Expense Benefit

Benefits are payable when a Covered Person incurs eligible drug expenses which are in excess of the copayment amount, per prescription or refill. No reimbursement will be made if a Covered Person chooses to have prescriptions filled at a pharmacy that does not participate in the Patient First Drug Program. The Covered Person must show the DCH Identification card in order to obtain the appropriate copayment. In the event the Covered Person must pay full retail price, the insured should file their claims through Patient First Drug Program. Forms may be obtained through the Benefits Office or CAS.

PARTICIPATING PHARMACIES:
Use the DCH Identification card at any participating pharmacy.

Each Covered Person will be responsible for the required copayment at the time of purchase. The remainder of the transaction will be handled between Patient First and the pharmacy.

The Covered Person is expected to show the DCH Insurance card to the member pharmacy when paying for the prescription. However, if the Covered Person does not have the card with them at the time of purchase, the Covered Person must:

1. Pay the full charge for the prescription;
2. Obtain a paid receipt which includes prescription information, not a cash register receipt only; and
3. Complete a Direct Reimbursement Patient First Prescription Drug Claim Form (available from the Benefits Office or CAS) with the pharmacist's help, attach the receipt and send both directly to Patient First at the address indicated on the claim form.

NO reimbursement will be made if a prescription is filled at a pharmacy that does not participate in the Patient First Drug Program.

NO Coordination of Benefits will apply for Prescription Drug Coverage.

Prescription Drug Coverage

This Plan may require a prescription to be approved prior to its being filled. If your prescription is rejected at the pharmacy, contact CAS at 478-741-3521 or 888-741-2673 to inquire about the Prior Authorization process.

The following list contains categories of retail Prescription drugs which are covered or excluded from the Plan.

C = Covered/ N = Not Covered

A.D.D. / Narcolepsy
C Amphetamines / Detroamphetamine (e.g. Adderall)
C Dextroamphetamine (e.g. Dexedrine) / through age eighteen (18)
C Methylphenidate (e.g. Ritalin) / through age eighteen (18)
C Pemoline (e.g. Cylert) / through age eighteen (18)

Anabolic Steroid
N Therapeutic classification (e.g. Winstrol, Durabolin)

Anorectics
N Therapeutic classification (e.g. Desoxyn, Fastin, Lonamin)

Appetite Suppressants
N Any drug used for the purpose of weight loss.

Birth Control (Contraceptives)
C Oral dosage forms (e.g. Ortho Novum, Demulen)
C Non-oral dosage forms (e.g. IUD, Diaphragm)
C Injectable dosage forms (e.g. Depo Provera)
C Levonorgestrel (Norplant) 5-year implant

Cosmetic Medication
C Accutane (for acne)
N Anti-wrinkle agents (e.g. Renova)
C Retin-A / through age eighteen (18)
N Pigmenting/depigmenting Agents (e.g. Solaquin Forte)

DESI Drugs
C All legend drugs which would otherwise be covered.

Diabetic Supplies (requires prescription from physician)
C Insulin
C Disposable Insulin Needles/Syringes (for insulin only)
C Blood/Urine testing agents (strips)

C Alcohol swabs
C Blood Glucose testing monitors
C Glucose Tablets
C Glucagon
C Lancets
C Lancet Devices
C Non-Insulin Needles Syringes (for administering prescribed medications)
C Insulin and needles/syringe under one co pay
C Insulin, needles/syringes, and test strips under one co pay

See also *Educational Services/Diabetes*.

Experimental or Investigational Drugs
This is NOT a covered Expense under your Plan.
Drugs labeled "Caution – limited by federal law to investigational use," or "Experimental drugs," even though a charge is made to the Covered Person.

Facility Administered Medication
These medications are not covered under this Plan's prescription drug coverage. However, they may be covered under Hospital Services.

Medication which is to be taken by or administered to a Covered Person, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

See also *Hospital Services*.

Fluoride Supplements
N Tablet forms
N Oral rinses
N Topical dental preparations

HIV / AIDS Medications
Pre-notification through CHS required.
C Therapeutic classifications (e.g. Hivid, Epivir, Videx, Zervit)

Imitrex (Motion Sickness)
C Oral dosage forms
C Injectable dosage forms

Infertility Medications
N Oral dosage forms (e.g. Clomid, Serophene)
N Injectable dosage forms (e.g. Metrodin, Pergonal)

Interferon
Pre-notification through CHS required.
C Therapeutic classification (e.g. Betaseron, Intron-A)

Miscellaneous Prescriptions
N Anti-Wrinkle Agents (e.g. Renoval)
N Blood and Blood Plasma (see hospital services)
C Growth Hormones (e.g. Humatropin, Genotropin)
N Immunization Agents (e.g. Hepatitis, Chicken Pox) (See *Routine Physical Exams*)
N Minoxidil (Rogaine-for the loss of hair)
C Impotency Drugs (e.g. Viagra, Cialis)

Non-Legend Drugs
N Over the counter medications

Nutritional Supplements
N Non-legend vitamins (over the counter)
N Legend vitamins
N Pediatric multi-vitamins with fluoride
C Prenatal vitamins
N Diet supplements (e.g. Calcium)
N Hernatinics (e.g. Folic Acid, Chromogen, Iron Supp.)
N Minerals (e.g. Phoslo, Potaba)

Prescriptions, Workers' Compensation Related
This is NOT a covered Expense under This Plan.
Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation Laws.

Smoking Cessation – only those drugs that require a doctor's prescription
C Gum (e.g. Nicorette)
C Patches (e.g. Habitrol, Nicoderm)

Therapeutic Devices
This is NOT a covered Expense under This Plan.
Therapeutic devices or appliances, including needles, syringes (except as specified), support garments and other non-medicinal substances, regardless of intended use.

Pre-Notification Requirements

Pre-Certification

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 $1,000 penalty.

Pre-certification 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, CHS requires that you obtain advance approval (pre-certification) for all scheduled inpatient and outpatient hospital treatment and all services performed in an Ambulatory Surgical Facility or Specialized Treatment Facility (Oncology Center, Dialysis Facility, etc.). Maternity admissions (see separate *Maternity Admissions*) also require notification. Under PPACA, emergency services no longer require precertification (see separate *Emergency or Urgent Inpatient or Outpatient Admissions*).[5]

The Employee, patient, family member, Employer, attending Physician, or Hospital can contact CHS for pre-certification 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 for pre-certification. **To avoid a penalty and obtain maximum benefits, pre-certification 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. Treatment must be pre-certified at least two (2) business days prior to date of service. You should notify CHS as soon as you know that a procedure has been scheduled and that you have to be admitted.

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 be Pre-Certified and will be subject to the Pre-Certification penalties

as defined in Pre-Notification Requirements.[3]

3. **Emergency or Urgent Inpatient or Outpatient Admissions** – The Plan does not require prior authorization to 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 Pre-Certification penalties as defined in Pre-Notification Requirements.

4. **Durable Medical Equipment** – all medical equipment in excess of $500 in purchase price require pre-authorization by CHS.

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

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 pre-certification request, please see the **Process for Appealing a Denied Medical Claim and/or Pre-Certification** if you received an adverse benefit determination with respect to your request for pre-certification.

Prior Determination

The following items require pre-certification:

- *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 pre-certification:

- *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

If the patient stays beyond the pre-certified time period, and the days are determined not to be Medically Necessary, room and board charges for these days will be denied.

If you need more time in the hospital, you may be certified for additional days while you are in the hospital. You, your hospital, or your attending Physician must call CHS no later than

the last day certified.

Concurrent review is the process of evaluating the continued hospital confinement. This telephonic review is also conducted by CHS nurse case managers. If additional days are judged to be medically necessary, CHS will grant certification. If the CHS nurse case manager's opinion differs with the attending physician's opinion, the case will be reviewed by a CHS physician and final determination will be made.

If the continued confinement is determined not to be medically necessary, CHS will communicate the denial to all involved parties (the Employee, hospital and attending physician). If the patient chooses to remain in the hospital beyond the certified number of days, the patient will be fully responsible for any remaining expenses that are incurred. If the patient or Employee wishes to appeal the decision to deny benefits for a continued confinement, he or she can submit an appeal in writing to CHS.

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

Pre-certification approval 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.

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-two (32) 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 of the month following satisfaction of the waiting period, 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; however, if the Spouse has other primary health coverage or is eligible for other primary health coverage (whether individual coverage, State provided coverage, and/or Federal provided coverage), the Spouse is not eligible for coverage under the Dodge County Hospital Employee Health Care Plan.
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; however, the child is not eligible for coverage under the Dodge County Hospital Employee Health Care Plan if:
    a. the child is covered under or eligible for State provided coverage and/or Federal provided coverage; or
    b. the other natural/adoptive/foster parent or legal guardian (i.e. the Employee's Spouse or Partner or former Spouse or Partner) has other coverage that

allows Dependent coverage and that parent's or guardian's birthday falls earlier in the year; unless the divorce decree or custody agreement specifies which parent must provide coverage for the child.

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. The Employee's natural child;
2. A legally adopted child from the date the Employee assumes legal responsibility;
3. A stepchild as long as the natural parent remains married to the Employee and resides in the Employee's household; or
4. A legal foster child; provided that one or both of the child's natural parents does not reside with the Employee as well. In addition, the foster child is not considered a Dependent if the welfare agency provides all or part of the child's support.
5. A child or children of which the covered Employee has been designated the Legal Guardian.

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 1st of the month after they become eligible, 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 be effective on the 1st of the month after they become eligible, 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 (30) 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 (30) day period of time surrounding a loss of other coverage for a Special Enrollee, or the thirty (30) 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, my 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, the first day of the first month beginning after the date of the completed request for enrollment is received;
- 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 first day of the next pay period, 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 first day of the next pay period of the Employee.

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.[6]

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 Step Child or Foster Child

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 other additions of coverage, the Change will be effective as of the 1st day of the Month following enrollment. For all other deletions of cover age, the change will be effective as of the last day of the month of the change itself.

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. If the covered Employee fails to remit required contributions for coverage when due, coverage will terminate at the end of the period for which a contribution is made;
2. Termination of the Active Service, except as specified below and in the COVERAGE AFTER TERMINATION section;
3. When the covered Employee enters the military, naval or air force of any country of international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any calendar year;
4. When the covered Employee ceases to maintain full-time residency in the United States of America; or
5. When the covered Employee ceases to be in a class eligible for coverage.

Family and Medical Leave Act of 1993 (FMLA)

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.[7] 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 (30) 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.

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. When the coverage of the covered Employee is terminated;
2. When the covered Employee ceases to make the required contributions for the Dependent;
3. When the covered Employee ceases to be in a class of Employees eligible for Dependent coverage;
4. When any Dependent ceases to meet the requirements of an eligible Dependent, except as specified below and in the COVERAGE AFTER TERMINATION provision;
5. When such Dependent enters the military, navel or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any calendar year;
6. When such Dependent ceases to maintain full-time residency In the United States of America; or

7. When Dependent coverage is discontinued under This Plan.

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.

Coverage After Termination

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

A Covered Person whose coverage has been terminated for any qualifying event enumerated below has the right to continue coverage for all benefits of This Plan if covered for such benefits on the day immediately preceding the termination date. The time period for which the continuation is available is indicated on the following pages in conjunction with the corresponding qualifying event.

If Continuation of Coverage is elected, coverage will continue as though termination of employment or loss of eligible status had not occurred. Any accumulation of deductibles or benefits paid prior to termination or loss of eligibility which had been credited toward any deductible or maximum benefit of This Plan will be retained.

Also, no new or additional waiting period will apply. If any changes are made to the coverage for Employees in Active Service, the coverage provided to individuals under this continuation provision will be similarly modified.

Qualifying Events

An EIGHTEEN (18) MONTH continuation is available to covered Employees and/or Covered Dependents if any one of the following qualifying events occurs:

1. A covered Employee's termination of employment for any reason except gross misconduct; or
2. A covered Employee's loss of eligibility to participate due to reduced work hours.

A TWENTY-NINE (29) MONTH continuation shall be available to all qualified beneficiaries if a Covered Person is disabled, per a determination under the Social Security Act, within sixty (60) days of the covered Employee's termination of employment or reduction in work hours.

The Covered Person must provide the Plan Sponsor with notice of the disability within sixty (60) days of the determination of the disability by Social Security and before the end of the original eighteen (18) month COBRA coverage period. The Covered Person must notify the Plan Sponsor of a determination by Social Security that the individual is no longer disabled within thirty (30) days of such determination.

A THIRTY-SIX (36) MONTH continuation shall be available to a Covered Dependent Spouse and/or child if any one of the following qualifying events occurs:

1. A covered Employee's death;
2. Divorce or legal separation from a covered Employee;
3. A Covered Dependent child's loss of eligibility to participate due to age; or
4. A Covered Dependent's loss of eligibility to participate in This Plan due to the covered Employee becoming covered by Medicare as a result of Total Disability or choosing Medicare in place of This Plan at age sixty-five (65).

If any Employee becomes covered by Medicare, but no loss of coverage results for the Employee or the Covered Dependents, and a subsequent qualifying event occurs, the duration of coverage for all qualified beneficiaries other than the covered Employee must be at least thirty-six (36) months from the date on which the Employee became covered by Medicare.

Notice of Continuation

A Covered Person has at least sixty (60) days form the date of loss of coverage as a result of a qualifying event or sixty (60) days from the date the Plan Sponsor mails or otherwise provides the Covered Person with a notification of the Covered Person's rights pursuant to a qualifying event to elect coverage. Payment of initial premium is not required until the forty-fifth (45th) day after the election. All payments for coverage after the date of election are subject to a thirty (30) day grace period.

The Covered Person is required to notify the Plan Sponsor within sixty (60) days of any qualifying event of which it would not otherwise be aware, such as divorce, legal separation, or loss of Dependent status by a Dependent child.

The Covered Person is required to notify the Plan Sponsor with all information needed to meet its obligation of providing notice and continuing coverage.

Cost of Continuation

Contact the Employer for details regarding the cost of continuation.

There may be other coverage options for each covered member. When key parts of the health care law take effect, a member will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, a member could be eligible for a new kind of tax credit that lowers their monthly premiums right away, and the member can see premiums, deductibles, and out-of-pocket costs before the member makes decision to enroll. Being eligible for COBRA does not limit a member's eligibility for coverage for a tax credit through the Marketplace. Additionally, a member may qualify for a special enrollment opportunity for another group health plan for which the member is eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if the member requests enrollment within 30 days.

Termination of Continuation of Coverage

Continuation of coverage shall not be provided beyond whichever of the following dates is first to occur:

1. The date the maximum continuation period expires from the corresponding qualifying event;
2. The date This Plan is terminated;
3. The date the individual failed to make the required contribution to continue coverage;
4. The date the individual becomes covered by Medicare (if the individual becomes

covered by Medicare as a result of end stage renal disease, coverage will continue until the maximum continuation period expires for the corresponding qualifying event); or

5. In the month that begins more than thirty (30) days after a final determination has been made that an individual is no longer disabled.

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 USSRRA 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.

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 Pre-Certification

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:

- *Pre-certification claims for Urgent Care*, as soon as possible but no later than 36 hours after an appeal is received.
- *Pre-certification 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 Pre-certification claims for Urgent Care,
- 15 days for Pre-certification 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 compete, 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.

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 CHIPRA

CHIPRA 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

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 that This Plan's subrogation rights are a first priority claim against any potentially liable party to be paid before any other claim for the Covered Person's general damages, and This Plan shall be entitled to reimbursement even if the payments 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 provision, a 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.

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 any questions about your Plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) or U.S. Department of

Labor, listed in your 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.

Notice of Privacy Practices

Privacy Officer: Contact Human Resources, 478-448-4105

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 dies.

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 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.

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.

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.

The Plan Sponsor is:
Core Management Resources Group, Inc.
515 Mulberry Street, Suite 300
Macon, GA 31201
478-741-3521

Plan Year

The Plan Year for This Plan is January 1 through December 31.

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 charges to the majority of patients for a given procedure. These charges must be within the range of fees charged by most Physicians 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.

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 Administrative Services
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.

Index

F

G

H

I

L

M

N

O

P

Q

R

S

T

U

V

W

X

Y

References

[1] *29 CFR 2520.102-3*
(Contents of Summary Plan Description)

[2] *29 CFR Chapter XXV*
45 CFR Subtitle A
(Coverage for Breast Reconstruction and Related Services after a Mastectomy; Proposed Rule [05/28/1999])

[3] *26 CFR Part 54,*
29 CFR Part 2590,
45 CFR Part 144, 146 & 148
(Group Health Plans and Health Insurance Issuers under Newborns' and Mothers' Health Protection Act; Joint Interim Rule [10/27/1998])

[4] *26 CFR Part 54 & 602,*
29 CFR Part 2590,
45 CFR Part 152
(Department of Health and Human Services – Pre-Existing Condition Insurance Plan Program; Interim Final Rule)

[5] *29 CFR Part 2590 Subpart C*

[6] *29 CFR Part 2590*
45 CFR Part 303
(National Medical Support Notice [11/15/1999])

[7] *29 CFR Part 825*
(Family Medical Leave Act 1993)