BARTON COUNTY COMMUNITY COLLEGE
EMPLOYEE HEALTH CARE PLAN

Summary Plan Description

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BARTON COUNTY COMMUNITY COLLEGE EMPLOYEE HEALTH CARE PLAN
SUMMARY PLAN DESCRIPTION

This Summary Plan Description ("SPD") describes the basic features of the Barton County Community College Employee Health Care Plan (the "Plan"). This SPD is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant. The SPD is not a part of the official Plan document. The SPD is also distinct from the Plan's Summary of Benefits and Coverage ("SBC"). ***If there is a conflict between the Plan document and this SPD (or, for that matter, the SBC), the Plan document will control.***

I. General Information

(A) ***Plan Sponsor.*** The name, address, telephone number, and Federal tax identification number of the Plan Sponsor are:

BARTON COUNTY COMMUNITY COLLEGE
245 NE 30 ROAD
GREAT BEND, KS 67530
(620) 792-9275
EIN: 48-0720175

(B) ***Employer.*** References to the "Employer" in this SPD mean, collectively, the Plan Sponsor and all Participating Plan Sponsors (if any).

(C) ***Named Fiduciary.*** The named fiduciary of the Plan is the Plan Sponsor.

(D) ***Claims Administrator.*** The Claims Administrator is Benefit Management, LLC. Benefit Management does not serve as an insurer, but merely as a claims processor. After claims for benefits are sent to Benefit Management, it processes the Claims and then requests and receives funds from the Plan Sponsor in order to make payment on the Claims to providers.

(E) ***Identification of Plan.*** The name of the Plan is the Barton County Community College Employee Health Care Plan (the "Plan").

(F) ***Plan Year / Benefit Year.*** The Plan Year, which refers to the period on which the Plan maintains its records, is November 1 through October 31. The Benefit Year, which refers to the period on which Claims will be paid under the Plan, is the same as the Plan Year.

(G) ***Effective Date of Plan.*** The Effective Date of this restated Plan is November 1, 2018. The original Effective Date of the Plan is November 1, 1997.

(H) ***Type of Plan.*** The Plan is a self-funded group health plan. The Plan is funded by the Employer; however, benefit Claims are processed by the Claims Administrator. Medical, Prescription Drug and Dental benefits will be provided through this Plan.

(I) ***Plan Administrator.*** The Plan Sponsor serves as the Plan Administrator in this Plan. The Plan Administrator is responsible for making sure that the Plan is administered according to its terms, for providing you and other participants with information about the Plan, for resolving any questions about participant eligibility and participant benefits, and for making any other discretionary determinations that need to be made in order for the Plan to function.

(J) ***Service of Process.*** The name of the person designated as the Agent for Service of Legal Process is Mark Dean, Vice President of Administration, whose address is the same as the Employer's address. In addition, service of process may be made upon the Plan Administrator at the address listed above for the Plan Sponsor.

II. Eligibility to Participate in the Plan

You will automatically become a Participant in the Plan on your Plan entry date if you satisfy the eligibility conditions for the Plan. Once you become a Participant, you will continue to be a Participant until the eligibility conditions are no longer met. These requirements are explained in more detail below.

(A) ***Eligible Individuals.*** You are eligible to participate in the Plan if you are:

(1) An Employee of the Employer.

(2) A Retired Employee of the Employer who satisfies the conditions in Section V.

(B) ***Excluded Individuals.*** You are not eligible to participate in this Plan under any circumstances if you are working for the Employer in any of the following capacities:

(1) Part-time / Variable Hour workers, meaning those persons regularly scheduled to work less than 40 hours per week.

(2) Employees covered by a collective bargaining agreement.

(3) "Seasonal / Temporary Employees," meaning employees who are employed either (i) on a seasonal basis into a position for which the period of customary employment is six months or less, or (ii) for only a short period of time, typically only as long as is necessary to perform a particular piece of work or a discrete assignment.

(4) "Leased employees," as that term is used in Section 414(n) of the Internal Revenue Code.

(5) Individuals who are enrolled in the Barton County Community College Level II Preventive Health Benefits Plan.

(C) ***Eligible Dependents.*** Your Dependents are eligible to participate in the Plan if they meet at least one of the following conditions:

(1) Spouse.
- Note that, for purposes of this Plan, a Spouse is a person of the same or opposite sex to whom you are legally married under the laws of the State in which the marriage was entered into, regardless of where you are currently living. A person will not be considered your Spouse under this Plan if (a) the marriage has been legally terminated by a court having jurisdiction over the marriage, (b) he/she is legally separated from you, or (c) either party to the marriage is legally married to another (third) party under the laws recognized by any State.

(2) Children up to age 26.

(3) Children who are older than 26 and disabled.

(D) ***Waiting Period.*** Before you and your Dependents can enter the Plan, you must have completed thirty (30) days of employment with the Employer. You will then enter the Plan on the first day of the first month coincident with or next following the date you have satisfied the Waiting Period.

If you terminate employment with the Employer and are later rehired into a position in which you are eligible to participate in the Plan, you must again satisfy the Plan's Waiting Period before you are able to participate in the Plan.

III. Commencement and Termination of Coverage Under the Plan

(A) ***Enrollment in the Plan.*** To become a Participant in the Plan, you must enroll using the forms provided by the Plan Administrator. These forms must be completed and returned to the Plan Administrator on or before your Plan entry date (or, if later, within the deadline for completing any enrollment materials, as set forth below). *If you do not complete the enrollment materials required by the Plan Administrator, you will not receive any benefits under the Plan.*

(1) *Failure to Enroll When First Eligible*. If you fail to enroll when you are first eligible to do so, you may not enroll in the Plan until the next Open Enrollment Period, in which case your enrollment will not take effect until the first day of the following Plan Year. The same rule applies if you fail to enroll your Dependents when they are first eligible to enter the Plan. In general, you must enroll in the Plan within 63 days of the date on which you first became eligible to participate in the Plan. There are, however, a number of exceptions to this rule, which are set forth below:

(2) *"Special Enrollment" Rights Pursuant to HIPAA.*

(a) Acquisition of New Dependent. If you acquire a new Dependent as a result of marriage, birth, adoption, or appointment of legal guardianship, you may enroll that Dependent outside the normal Open Enrollment Period. To do so, you must enroll them in this Plan (by completing any required enrollment materials) within 63 days of the marriage, birth, adoption, or legal guardianship appointment.

(b) Loss of Other Group Health Plan Coverage. If you declined enrollment in the Plan for yourself and/or your Dependents because you and/or your Dependents were enrolled in another group health plan or health insurance policy, and that other coverage is subsequently lost, you may enroll yourself and/or your Dependents in this Plan outside the normal Open Enrollment Period. To do so, you must enroll in this Plan (by completing any required enrollment materials) within 63 days after your other coverage ends.

(c) Eligibility (or Loss of Eligibility) for Premium Assistance Under Medicaid or SCHIP. If you or your Dependent become eligible for a state premium assistance subsidy under the Plan from either Medicaid or a state's children's health insurance program (SCHIP), or if you or your Dependent lose eligibility for Medicaid or SCHIP, you and/or your Dependent may enroll in the Plan outside the normal Open Enrollment Period. To do so, you must enroll yourself (and/or your Dependent) in this Plan by completing any required enrollment materials) within 63 days of the applicable event.

(d) Special Tag-Along Rule. If you and/or your Dependent(s) enroll in the Plan by virtue of the HIPAA "special enrollment" rights set forth above, any other Dependents who are eligible, but not currently enrolled in the Plan, may enroll at the same time. This is known as the "tag-along" rule adopted by the Plan.

(3) *Qualified Medical Child Support Orders*. The Plan will enroll and provide coverage to any of your Dependents who are the subject of a Qualified Medical Child Support Order ("QMCSO"), consistent with the terms of the QMCSO and any applicable federal laws and regulations. An appropriately completed National Medical Support Notice will be deemed to be a QMCSO for purposes of this Plan. You and your Dependents may obtain from the Plan Administrator, free of charge, a copy of the Plan's procedures governing the determination of whether an order is a QMCSO.

(4) *Reasons Permitted by Cafeteria Plan Regulations*. If a Dependent of yours is not covered by the Plan, but later becomes eligible to enroll in the Plan for a reason permitted by the Employer's cafeteria plan, you may enroll the Dependent in the Plan outside the normal Open Enrollment Period by completing the required enrollment materials within 63 days.

(B) ***Plan Entry Date for Participants.*** If you have met the Plan's eligibility conditions (including any Waiting Period) and you have completed all of the required enrollment materials, you will enter the Plan on the first day of the month coincident with or next following the completion of the Waiting Period.

EXAMPLE #1. You are hired as a full-time Employee on March 15. You complete thirty (30) days of employment with the Employer on April 13 and you enroll in the Plan using the form(s) provided by the Plan Administrator. You will enter the Plan on the first day of the next month, which is May 1.

However, if you are enrolling in this Plan based on your loss of coverage in another group health plan or insurance policy, then you will enter the Plan on the first day of the month coincident with or next following the date on which the Plan Administrator receives your enrollment materials.

**** *Special Rule for Retirees*. If you meet the Plan's eligibility conditions for coverage as a Retiree and you timely submit your enrollment materials to the Plan Administrator, your coverage as a Retiree will begin on the first day of the month coincident with, or next following the date on which you terminated employment with the Employer at a time that you satisfied the eligibility conditions for Retiree coverage. See Section II(A) above.

(C) ***Plan Entry Date for Dependents.*** In general, your Dependents (whom you have timely enrolled) will enter the Plan at the same time as you. If you had been participating in the Plan but one or more of your Dependents had not, you may enroll such Dependents during the Open Enrollment Period, at which point their coverage will commence on the first day of the Plan Year. If you wish to enroll a Dependent outside of the Open Enrollment Period based on one of the special enrollment rights described in Section III(A) above, the following rules apply with respect to the Dependent's commencement of coverage under the Plan:

(1) *Newborn and Newly Acquired Children*. If your newborn or newly acquired Child (via adoption or appointment of legal guardianship) is properly enrolled in the Plan, the Child will enter the Plan on:

(a) The date of birth in the case of a natural or adopted newborn Child; or

(b) In the case of a child other than a newborn, the date the child is placed in the Participant's home for adoption, or the date the court awards legal guardianship to the Participant and/or his/her Spouse.

(2) *New Spouse*. If your new spouse is properly enrolled in the Plan, he/she will enter the Plan on the date of the marriage.

(3) *New Dependent Eligibility Based on Loss of Other Group Health Plan Coverage*. If you are enrolling your Dependent in this Plan based on his/her/their loss of coverage in another group health plan or insurance policy, then the Dependent(s) will enter the Plan on the first day of the month coincident with or next following the date on which the Plan Administrator receives the enrollment materials.

(4) *All Other Situations*. For all other situations in which you are permitted to enroll a Dependent outside the normal Open Enrollment Period, the Dependent will enter the Plan on the first day of the month coincident with or next following the date that the Dependent becomes eligible for coverage under the Plan, provided that the Plan Administrator receives the enrollment materials within the time period required by the Plan.

(5) *Special Rule for Dependents Entering Plan Pursuant to Tag-Along Rule*. If a Dependent is being enrolled in the Plan pursuant to the tag-along rule (*see* Section III(A)(2)(d) of this SPD), the Plan may, for administrative convenience, allow such Dependent to enter the Plan at the same time as the Participant and/or other Dependent(s), even if it is earlier than the time that such Dependent would otherwise be permitted to enter the Plan.

(6) *Dependents of Retirees*. The Dependents of a Retiree may participate in the Plan only if they were already covered under the Plan at the time of the Retiree's termination of employment with the Employer.

(D) ***Termination of Participant's Coverage.*** Your participation in the Plan will end at the end of the last day of the month coincident with or next following your loss of eligibility or termination of employment.

Please note that, while your coverage for benefits under the Plan ends with the termination of your participation, you may be entitled to purchase COBRA continuation coverage.

(E) ***Termination of Coverage of Dependent.*** Your Dependent's participation in the Plan ends at the end of the month coincident or next following the date on which the Dependent ceases to satisfy the eligibility conditions of the Plan.

Please note that, while your Dependents' coverage for benefits under the Plan ends simultaneously with the termination of your participation, your Dependents may be entitled to purchase COBRA continuation coverage.

IV. Continuation Coverage Under the Plan

(A) ***COBRA Continuation Coverage – In General.*** If the coverage for you and/or your eligible Dependent(s) under the Plan terminates because of certain "qualifying events" specified in a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), then you and/or your eligible Dependent(s) may have the right to purchase continuing coverage under the Plan for a limited period of time. COBRA requires that continuation coverage must be offered to "qualified beneficiaries" (described below) who lose their coverage under the Plan as a result of certain "qualifying events" (described below), so long as the qualified beneficiary timely notifies the Plan Sponsor of the "qualifying event" and pays any applicable premiums.

(B) ***Qualified Beneficiaries.*** Under COBRA, "qualified beneficiaries" include you and/or any of your Dependents who were covered under the Plan on the day before the "qualifying event." Qualified beneficiaries also include any children who are born to, or adopted by, you while you are continuing your coverage pursuant to COBRA.

(C) ***Qualifying Events.*** A "qualifying event" includes any of the following occurrences if you (or another qualified beneficiary) would otherwise lose your/their eligibility for coverage under this Plan as a result of such an event:

(1) Termination of your employment (other than for "gross misconduct") or a reduction in the number of hours you normally work;

(2) Your death;

(3) Divorce or legal separation from your covered Spouse;

(4) Entitlement to Medicare (Part A, Part B, or both); or

(5) Covered Dependent no longer satisfies the conditions for being covered as a Dependent under the Plan;

(D) ***Notice Procedures.*** When the qualifying event is a termination of your employment, reduction in hours of your employment, or your death, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Plan Administrator of any of these three qualifying events. **For all other qualifying events, you must notify the Plan Administrator in writing within 60 days after the date on which the qualifying beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. If notice of a qualifying event is not timely made within the 60-day notice period, no COBRA coverage may be elected by any qualified beneficiary.**

(E) ***Election to Continue Coverage.*** Once the Plan Administrator receives *timely* notice that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect continuation coverage. For example, your covered Spouse may elect COBRA even if you do not. COBRA may be elected for one, several, or all of your covered Dependent children who are qualified beneficiaries. You may elect COBRA coverage on behalf of your covered Spouse, and either you or your Spouse may elect COBRA coverage on behalf of your children. For each qualified beneficiary who timely elects COBRA coverage, such coverage will begin on the date that Plan coverage would otherwise have been lost.

(F) ***Premium for COBRA Continuation Coverage.*** A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage along with an additional 2% charge or, with respect to an extension of the maximum coverage period due to a subsequent disability, an additional 50% charge. Premiums must be paid on a timely basis or else COBRA coverage will be terminated.

(G) ***Maximum Coverage Period.*** The maximum period of time for which COBRA continuation coverage will be provided shall be as follows:

(1) *Termination of Employment or Reduction in Hours.* If coverage is lost as a result of your termination of employment or a reduction in your hours, the maximum period of COBRA continuation coverage will be 18 months.

(2) *Disability Extension.* If a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage and the qualified beneficiary notifies the Plan Administrator of such determination (a) within 60 days of such determination and (b) while COBRA continuation coverage is still in effect, the maximum period of COBRA continuation coverage will be 29 months.

(3) *Second Qualifying Event.* If a second qualifying event takes place while coverage is being continued following the original qualifying event and the second qualifying event is other than the termination of your employment or a reduction in your hours, the maximum period of COBRA continuation coverage will be 36 months.

(4) *Any Other Qualifying Event.* The maximum period of COBRA continuation coverage will be 36 months for any qualifying event for which a shorter maximum coverage period is not set forth in this Subparagraph (H).

(5) *Calculation of COBRA Deadlines.* The maximum coverage period shall begin as of the date on which the qualified beneficiary would otherwise lose coverage as a result of the original qualifying event (as opposed to beginning on the date of the qualifying event itself). The deadline for the Employer to notify the Plan Administrator of a qualifying event (if applicable) and the deadline for a qualified beneficiary to notify the Plan of a qualifying event (if applicable) shall also be measured from the date that coverage is lost.

(H) ***Termination of COBRA Continuation Coverage.*** COBRA continuation coverage may be terminated prior to the expiration of the maximum coverage period if any of the following circumstances occur:

(1) *Covered Under Another Group Health Plan*. The qualified beneficiary becomes covered under another group health plan;

(2) *Premium Not Paid*. A required premium is not paid within the applicable deadline (including any applicable grace period);

(3) *Plan is Terminated with No Other Coverage Offered in its Place*. The Employer terminates this Plan and no longer offers coverage under a group health plan to any of its Employees;

(4) *Entitlement to Medicare*. After electing COBRA coverage, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both);

(5) *No Longer Disabled*. During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or

(6) *Other Analogous Reasons for Terminating Coverage*. Coverage would have been terminated under the same circumstances for a Covered Person who is not receiving COBRA continuation coverage (e.g., if the Covered Person engages in fraudulent activities against the Plan).

(I) ***Coverage Provided During COBRA Continuation Period.*** The coverage provided during the COBRA continuation period shall be identical to the coverage provided to similarly situated persons covered under the Plan with respect to whom a qualifying event has not occurred. This includes open enrollment and special enrollment rights. If coverage under the Plan is modified for any group of similarly situated persons, the coverage shall also be modified in the same manner for all qualified beneficiaries who have elected to continue their coverage under COBRA.

V. Special Retiree Coverage for Kansas Municipal Employees

If you have at least ten (10) years of service with the Employer at the time of your retirement, you (and any Spouse and/or dependents who are covered through you at the time of your retirement) may elect to continue coverage in the Plan if each of the conditions set forth below are satisfied:

(A) *Waiver of COBRA*. You waive your right to elect COBRA continuation coverage.

(B) *Timely Election to Continue Coverage*. You affirmatively elect to continue coverage under the Plan no later than thirty (30) days after your retirement from employment with the Employer.

Note: For purposes of this special retiree coverage, the term "retirement" means that you have terminated employment and are receiving a retirement or disability benefit for your service with the Employer.

(C) *Payment of Premium.* You must pay the entire cost of coverage for this retiree continuation coverage. Although the exact premiums will be determined by your Employer, the Employer may also require that you pay an administrative fee of up to 25% of the cost of the coverage.

Termination of Continuation Coverage. Your special retiree continuation coverage will terminate upon the earliest occurrence of the following events:

(1) You turn age sixty-five (65);

(2) You become covered, or become eligible to be covered, under another employer's group health plan;

Note: The reference to "another employer's group health plan" only refers to an employer of the Participant himself/herself.

(3) You fail to make a required premium payment on a timely basis; or

(4) The Employer terminates the Plan.

Coverage of Your Spouse and/or Dependents. If you elect to continue coverage under this special retiree continuation coverage, you may also elect to cover your Spouse and/or Dependent(s) who were covered through you under the Plan as of your retirement from employment with the Employer. In order for any such individuals to be covered, however, they also must waive their right to elect COBRA continuation coverage. The coverage of such Spouse and/or Dependent(s) shall terminate upon the earliest occurrence of the following events:

(1) Your coverage under the Plan terminates;

(2) Your Spouse and/or Dependent (as applicable) turns age sixty-five (65);

(3) You fail to make a required premium payment on a timely basis;

(4) Your Spouse and/or Dependent becomes covered, or becomes eligible to be covered, under another employer's group health plan; or

(5) The Employer terminates the Plan.

Construction and Application. This section shall be construed and applied in a manner consistent with the requirements of Kansas Statutes Annotated 12-5040.

VI. USERRA Continuation Coverage Under the Plan

USERRA Continuation of Coverage. If you are absent from employment as a result of military service, you have the right to elect continuation coverage for a period of up to twenty-four (24) months if such coverage would otherwise be lost as a result of such military service. Your right to continue coverage is subject to the following:

(1) *Payment of Premium.* You must pay the applicable premium for any USERRA continuation coverage. For a leave of absence for thirty (30) days or less, you will not be required to pay more than what you would have paid had you not been on leave. For a leave of absence of more than thirty (30) days, you may be required to pay up to 102% of the applicable premium under the Plan.

(2) *Exclusions or Waiting Period Upon Reinstatement.* The Plan may impose a Pre-Existing Condition exclusion or Waiting Period for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, your performance of qualified military service.

(3) *Failure to Apply for Reemployment.* Following completion of your military service, your right to continue coverage under USERRA will end if you do not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).

VII. FMLA Continuation Coverage Under the Plan

(A) ***Continuation of Coverage While on Family and Medical Leave.*** If you take unpaid leave under the Family and Medical Leave Act ("FMLA"), the Employer will, to the extent required by the FMLA, continue to maintain your benefits under the Plan on the same terms and conditions as if you were still an active Participant. If you choose to continue your coverage while you are on a FMLA leave, the Employer will continue to pay its share (if any) of the premiums. However, you will be required, if you choose to continue your coverage, to pay your share of the premiums in one or more of the following ways:

(1) You may pay your share of the premiums with after-tax dollars while you are on FMLA leave.

(2) You may pay all or a portion of your share of the premium prior to your FMLA leave.

(B) ***COBRA Coverage Following FMLA Leave.*** If you take FMLA leave and do not return to work at the end of your FMLA leave, you (and/or your Dependents) may be entitled to elect COBRA continuation coverage following such leave if each of the following is true:

(1) Each individual seeking COBRA continuation coverage was covered under the Plan on the day before your FMLA leave began (or became covered during your FMLA leave);

(2) You did not return to employment with the Employer following your FMLA leave; and

(3) You (and your Dependents, as applicable) would, in the absence of COBRA coverage, lose coverage under the Plan within 18 months of your last day of FMLA leave.

If the elements set forth above are satisfied, you (and/or your Dependents) will be eligible to seek COBRA continuation coverage following your FMLA leave regardless of whether you (and your Dependents, if applicable) were covered under the Plan during your FMLA leave. COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.

VIII. Benefits Available Under the Plan

The Plan makes certain health benefits available to Covered Persons. A detailed summary of the specific benefits and scope of coverage is set forth in the Plan's Benefit Description, which is available from the Plan Administrator.

The Plan Sponsor shares the cost of coverage under this Plan with covered Employees. The level of Employee premiums/contributions is set by the Plan Sponsor. The Plan Sponsor reserves the right to change the level of Employee premiums/contributions prior to the commencement of each Plan Year.

IX. Plan's Right to Recover Benefits – Subrogation & Reimbursement

(A) ***Subrogation.*** The right of subrogation means the right of the Plan to "step into your shoes" and take over your right to receive payments from third parties or to pursue a cause of action against third parties, to the extent of payments made by the Plan. By accepting benefits from the Plan, you are agreeing to the Plan's right of subrogation to any Claim or right of action that you may have against a third party. You may be required to sign an agreement affirming the Plan's right to subrogation before any benefits will be paid to you (or on your behalf) in connection with a particular injury or condition.

> *Example of Subrogation:* You are injured in a car accident and the Plan pays your medical expenses resulting from the accident. You have a Claim against the other driver for your injuries. The Plan may make a Claim against the other driver because either (1) you do not assert a Claim against the driver, or (2) you assert a Claim against the other driver, but it does not include damages for medical expenses that were paid by the Plan.

(B) ***Reimbursement.*** The right of reimbursement is the right of the Plan to recover from you or your covered Dependent any and all benefits previously paid by the Plan with respect to an injury or condition in the event you are compensated for such injury or condition from any source, whether by settlement, judgment, compromise, or otherwise. The right to reimbursement also includes future medical expenses, if any. By accepting benefits under the Plan, you are agreeing to reimburse the Plan out of any recovery you might receive from third parties. If you bring a liability Claim against any third party, benefits payable under this Plan must be included in the Claim. Moreover, the Plan has a right to reimbursement from you, your Covered Dependent(s), and/or any assignee(s) for any benefit overpayments attributable to mistake, clerical error, fraud, or any other reason contributing to a payment not fully payable under the terms of the Plan.

You must not do anything which would prejudice the Plan's rights of reimbursement. You may be required to sign and deliver documents reasonably necessary to secure the rights of the Plan to reimbursement.

> *Example of Reimbursement:* You are injured in a car accident and the Plan pays your medical expenses resulting from the accident. You bring a Claim against the other driver for your injuries, which you eventually settle against the other driver. The Plan is entitled to immediate reimbursement from what you recovered in your settlement for *all benefits* paid by the Plan in connection with your injuries. *You may not reduce the amount owed the Plan in order to account for attorney fees and costs*. Further, the Plan must be paid *first* out of the *total* amount of the settlement.

(C) ***Amount Due.*** The amount owed to the Plan may not be reduced by the attorney fees and costs incurred in asserting your Claim against third parties. Moreover, the Plan's rights of subrogation and reimbursement take precedence over your right to be made whole.

(D) ***Condition of Payment.*** At the Plan's request, you (or your covered Dependent) must take any action, give information, and/or execute instruments required by the Plan, in its discretion, in order to aid the Plan in its enforcement of its rights of recovery through reimbursement and subrogation. If you (or your covered Dependent) fail to comply with such requests, the Plan may withhold benefits, services, payments, or credits due under the Plan.

(E) **Notice of Potential Third-Party Liability.** If a third party may be liable for an injury or illness for which the Plan has paid benefits, you must provide notice to the Plan of such third party's potential liability before commencing a legal action against that third party. If a settlement is reached with that third party (or its insurer) without the formal filing of a legal action, you must provide notice of such settlement to the Plan before the settlement is finalized.

(F) ***Coordination of Benefits.*** If you (or your Covered Dependent) seek benefits under this Plan that are also payable under another medical plan or medical reimbursement arrangement (such as Medicare), the plans will coordinate how benefits are to be paid. The procedures governing this coordination of benefits are set forth in the Core Document.

(G) **Proceeds from Judgment/Settlement Are Plan Assets.** Any amount that you (or your covered Dependent) recover from a third party in connection with a judgment, settlement, or otherwise that arises out of an injury for which the Plan has paid benefits will be considered plan assets, thereby rendering you (or your covered Dependent) a fiduciary with respect to those plan assets. The Plan, in turn, may fully enforce its rights against you (or your covered Dependent) under applicable federal and/or state law.

X. Claims Procedures

If you have a Claim for benefits under the Plan, you must follow the procedures outlined in Appendix A of this SPD. The Claims Administrator of the Plan is Benefit Management. Please note that Benefit Management has been delegated full discretionary authority in connection with the Plan's internal claims appeal process to make all determinations regarding the administration and payment of Claims, in accordance with the terms of the Plan.

XI. Language Assistance

This SPD contains a summary in English of your rights and benefits under the Plan. If you have difficulty understanding any part of this SPD, please contact the Plan Sponsor/Plan Administrator at the address or telephone listed in Section I(A) for assistance.

XII. Amendment or Termination of the Plan

The Plan Sponsor may amend or terminate the Plan at any time by written instrument. Any change to the Plan will be added to the Plan document in writing and communicated to the participants.

APPENDIX A – CLAIMS PROCEDURES

In filing a Claims Appeal under the Plan, you must follow the procedures that are applicable to the specific type of Claim you are appealing. There are five different types of Claims, each of which is defined in a separate part of this Appendix. The various claims are: Urgent Care Claims (Part II); Pre-Service Claims (Part III); Concurrent Care Decisions (Part IV); Post-Service Claims (Part V); and Rescissions of Coverage (Part VI).

PART I – GENERAL PROCEDURES FOR FILING ANY TYPE OF CLAIMS APPEAL

Section A.01 Where to File Claims Appeal. A Claims Appeals must be filed in writing (with the exception of certain Urgent Care claims appeals, as described in Section A.08 below) with the Claims Administrator. Written Claims Appeals shall be sent to the Claims Administrator at the address below:

Benefit Management, LLC
Attn: Claim Appeal Review
P.O. Box 1090
Great Bend, KS 67530-1090

Section A.02 Persons Who May File Claims Appeals. Claims appeals may be filed by the Claimant or by the Claimant's duly authorized representative.

(a) Prior to recognizing any such appointment of an authorized representative, the Claims Administrator may require proof that the representative has been duly appointed.

(b) Notwithstanding the foregoing rule, a health care professional with knowledge of the Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant with respect to an Urgent Care Claims Appeal.

(c) For purposes of these claims procedures, the deadlines applicable to a Claimant shall apply to his/her authorized representative in the event he/she elects to use an authorized representative in filing any Claims Appeal.

Section A.03 Important Definitions in Claims Procedures. The following definitions apply to the claims procedures set forth in this Article of the Plan:

(a) ***Adverse Benefit Determination***. If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively on the basis of fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

(b) ***Appeal***. A Claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." An Appeal will be recognized as valid only if it is submitted by a Claimant or his/her authorized representative in accordance with the Plan's procedures for filing an Appeal of an Adverse Benefit Determination.

(c) ***External Review***. After receiving a Final Adverse Benefit Determination under the Plan's internal Appeal procedure, a Claimant has the right to request an External Review of his/her Claim pursuant to the Plan's External Review procedures, which are set forth in Part VII of this Appendix.

(d) ***Final Adverse Benefit Determination***. If a Claim is denied at the end of the internal Appeal process, the Plan's final decision is known as a "Final Adverse Benefit Determination."

(e) ***Receipt/Received***. The Plan Administrator (or its designee) will be deemed to be in "Receipt" of (or to have "Received") a Claimant's Claim, Appeal, or other information submission only after the Claim, Appeal, or other information submission is received – through electronic means or otherwise – in the physical offices of the Plan Administrator (or its designee). A Claimant will be deemed to be in Receipt of a request for additional information or other notification from the Plan upon *the earlier of* (i) the date that the request/notification is communicated to him/her electronically, or (ii) five (5) days after the request/notification is mailed to his/her mailing address.

Section A.04 Mandatory Exhaustion of Administrative Remedies. Prior to initiating legal action concerning a Claim in any court, state or Federal, against this Plan, any trust used in conjunction with this Plan, the Employer, the Claims Administrator, and/or the Plan Administrator, a Claimant must first exhaust the internal administrative remedies provided in this Article. Failure to exhaust the internal administrative remedies provided in this Article shall be a bar to any civil action concerning a Claim for benefits under this Plan.

Section A.05 Litigation Following Exhaustion of Administrative Remedies. Once a Claimant has exhausted his/her administrative remedies as set forth in this Article, he/she may file a lawsuit challenging the denial of the Claim. *Such lawsuit must be commenced, however, no later than 180 days after the Plan issues a Final Adverse Benefit Determination or, if External Review is sought by the Claimant, no later than 180 days after the Claim is denied in whole or in part on External Review*.

Sections A.06 Compliance with Federal Regulations Governing Claims Procedures. The claims procedures in this Article VI are intended to comply with all applicable federal regulations governing claims procedures for group health plans. The provisions in this Article shall be interpreted, therefore, to comply with all applicable federal regulations and guidance.

PART II – URGENT CARE CLAIMS APPEALS

Section A.07 Definition of Urgent Care Claim. An Urgent Care Claim is a Claim for medical care or treatment in which:

(a) The Plan conditions the receipt of benefits, in whole or in part, on advance approval of the particular care or treatment; and

(b) Using the timetable for deciding non-Urgent Care determinations (e.g., Pre-Service Claims and Post-Service Claims) (*see* Sections A.22 and A.36 below):

(1) Could, in the judgment of a prudent layperson with average knowledge of health and medicine, seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or

(2) Would, in the opinion of a Physician with knowledge of the Claimant's medical condition, subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

Section A.08 **How to File an Urgent Care Claim.** An Urgent Care Claim must include the following information:

(a) The medical care or treatment for which approval is being sought;

(b) The name of the person, organization, or entity to which the expense is to be paid;

(c) The name of the Claimant for whom the approval is being sought and, if such person is not the Employee (or covered class member) requesting the benefit, the relationship of such Claimant to the Employee (or covered class member);

(d) An explanation of why the medical care or treatment in question should be considered to be urgent;

(e) The amount expected to be recovered under any insurance arrangement or other plan with respect to the expense;

(f) A statement that the expense (or portion thereof for which reimbursement is sought under this Plan) has not been reimbursed and is not reimbursable under the Plan; and

(g) Any other information relating to the medical care or treatment in question that the Claimant considers relevant and wishes the Claims Administrator to consider in reviewing the Claim.

An Urgent Care Claim may be filed in writing. If the circumstances make the filing of a written Claim impractical, however, an Urgent Care Claim may also be submitted to the Claims Administrator electronically, over the telephone, or in some other way that is similarly expeditious and that ensures that the Urgent Care Claim is received by the Claims Administrator on a timely basis.

Section A.09 **Time Period for Filing an Urgent Care Claim.** An Urgent Care Claim must be filed with the Claims Administrator as quickly as possible after the Claimant becomes aware of the existence of the Claim.

Section A.10 **Failure to Follow Proper Procedures in Filing an Urgent Care Claim.** If the Claimant fails to follow the proper procedures in filing an Urgent Care Claim, the Claims Administrator shall notify the Claimant as quickly as possible. In no event, however, will the notification be made more than 24 hours after the time the failure took place.

Section A.11 **Failure to Submit Necessary Information.** If the Claimant fails to submit information that is necessary to process an Urgent Care Claim, the Claims Administrator shall notify the Claimant of such failure no more than 24 hours after Receipt of the Urgent Care Claim and shall identify the specific information that is necessary to complete the Urgent Care Claim.

(a) Upon Receipt of such notification, the Claimant shall have 48 hours to provide the requested information to the Claims Administrator.

(b) During the period between the date the additional information is requested and the date it is received by the Claims Administrator, the deadline for deciding the Urgent Care Claim, as set forth in Section A.12, shall be suspended.

(c) Following Receipt of the additional information that was requested by the Claims Administrator, the Claims Administrator shall decide the Urgent Care Claim as soon as possible, but no later than 48 hours after Receipt of the additional information.

Section A.12 Deadline for Deciding an Urgent Care Claim. Following the submission of an Urgent Care Claim that has been filed in accordance with the provisions of this Article, the Claims Administrator shall decide the Urgent Care Claim as quickly as possible, but no later than 72 hours after the Urgent Care Claim was received.

Section A.13 Notification Regarding Initial Benefit Determination on an Urgent Care Claim. The Claims Administrator shall notify the Claimant of the decision that has been made on the Urgent Care Claim. If the Urgent Claim was denied in whole or in part – which is considered an Adverse Benefit Determination – the notice provided to the Claimant shall be provided in a manner that is calculated to be understood by the Claimant. This notification may be provided orally if a written notification is provided within three (3) days after the oral notification.

Section A.14 Deadline for Filing Appeal of an Urgent Care Claim. Although a Claimant is encouraged to file any Appeal of an Adverse Benefit Determination on an Urgent Care Claim as soon as possible, the Claimant shall have up to 180 days following his/her Receipt of the notice of Adverse Benefit Determination to file the Appeal. Any Appeal shall be filed with the Claims Administrator.

Section A.15 Procedures for Appealing Adverse Benefit Determination of Urgent Care Claim. In any Appeal of an Adverse Benefit Determination on an Urgent Care Claim, the following procedures shall be observed:

(a) If requested by the Claimant, the Claims Administrator shall permit the Claimant to submit – where feasible – any information relevant to his/her Appeal either orally or in writing in order to expedite the processing and consideration of the Appeal. All necessary information shall be transmitted between the Claims Administrator and the Claimant by telephone, facsimile, electronic mail, or similar delivery method;

(b) The Claimant shall have the right to present evidence and written testimony as part of the Appeal process;

(c) The evaluation of the Claimant's Appeal shall take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) The Claims Administrator shall designate an appropriate individual or individuals to consider the Appeal. The individual(s) considering the Appeal shall not be the same individual(s) who originally decided the Claim nor shall they be subordinates of the individual(s) who originally decided the Claim;

(e) In considering the Appeal, no deference shall be given to the initial Adverse Benefit Determination;

(f) If the initial Adverse Benefit Determination was based on the Claim being not Medically Necessary or constituting Experimental or Investigational treatment, or some similar exclusion or limit, the individual(s) considering the Appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine

involved in the medical judgment. Any health care professional who is consulted for this purpose shall not have been involved with or consulted regarding the initial Adverse Benefit Determination nor shall such a professional be a subordinate of any professional who was involved with or consulted regarding the initial Adverse Benefit Determination;

(g) If the Claims Administrator has considered, relied upon, or generated any new or additional evidence in denying the Claimant's Appeal, the Claimant must be advised of his/her right to receive, free of charge, a copy of such new or additional evidence and his/her right to respond in writing; and

(h) In connection with the Appeal, the Claims Administrator must identify any medical or vocational experts whose advice was obtained on behalf of the plan in making the initial Adverse Benefit Determination, regardless of whether such advice was relied upon in making the initial Adverse Benefit Determination.

Section A.16 Deadline for Deciding Appeal of Denial of Urgent Care Claim. An Appeal of an Adverse Benefit Determination on an Urgent Care Claim shall be decided within 72 hours following the Claims Administrator's Receipt of the Claimant's request for the Appeal. The Claims Administrator shall notify the Claimant in writing of the decision made on his/her Appeal of an Adverse Benefit Determination of an Urgent Care Claim.

PART III – PRE-SERVICE CLAIMS

Section A.17 Definition of Pre-Service Claim. A Pre-Service Claim is a Claim for which each of the following conditions is satisfied:

(a) The benefit payable by the Plan depends, in whole or in part, upon the pre-approval (or pre-certification) of the underlying medical care or treatment in advance of obtaining the medical care or treatment; and

(b) The Claim is not an Urgent Care Claim (as defined in Section A.07).

Note: A total rescission of Plan coverage as a result of alleged fraud or misrepresentation is not considered a Pre-Service Claim.

Section A.18 How to File a Pre-Service Claim. A Pre-Service Claim shall include the following information:

(a) The amount, date and nature of each expense;

(b) The name of the person, organization or entity to which the expense is to be paid;

(c) The name of the Claimant for whom the approval is being sought and, if such person is not the Employee (or covered class member) requesting the benefit, the relationship of such Claimant to the Employee (or covered class member);

(d) An explanation of why the medical care or treatment in question should be approved;

(e) The amount expected to be recovered under any insurance arrangement or other plan with respect to the expense;

(f) A statement that the expense (or portion thereof for which reimbursement is sought under this Plan) has not been reimbursed and is not reimbursable under the Plan; and

(g) Any other information relating to the medical care or treatment in question that the Claimant considers relevant and wishes the Claims Administrator to consider in reviewing the Claim.

Section A.19 Time Period for Filing a Pre-Service Claim. A Pre-Service Claim must be received by the Claims Administrator sufficiently in advance of the proposed treatment date that the Claims Administrator is able to process the Claim.

Section A.20 Failure to Follow Proper Procedures in Filing a Pre-Service Claim. If the Claimant fails to follow the proper procedures in filing his/her Pre-Service Claim, the Claims Administrator shall notify the Claimant as quickly as possible. In no event, however, will the notification be made more than five (5) days after the time the failure took place. The Claimant shall then have 45 days to resubmit his/her Claim following the proper procedures.

Section A.21 Failure to Submit Necessary Information. If the Claimant fails to submit information that is necessary to process a Pre-Service Claim, the Claims Administrator shall notify the Claimant of such failure no more than 15 days after Receipt of the Claim and shall identify the specific information that is necessary to complete the Claim.

(a) Upon Receipt of such notification, the Claimant shall have 45 days to provide the requested information to the Claims Administrator.

(b) During the period between the date the additional information is requested and the date it is received by the Claims Administrator, the deadline for deciding the Claim, as set forth in Section A.22, shall be suspended.

(c) Following Receipt of the additional information that was requested by the Claims Administrator, the Claims Administrator shall decide the Claim within the number of days that were remaining in the original 15-day period (as extended) as of the date the additional information was requested.

(d) If the requested information is not received by the Claims Administrator within 45 days after the Claimant or the Claimant's authorized representative received the Claims Administrator's request for such information, the Claims Administrator shall deny the Claim.

Section A.22 Deadline for Deciding a Pre-Service Claim. Following the submission of a Pre-Service Claim that has been filed in accordance with the provisions of this Article, the Claims Administrator shall decide the Pre-Service Claim not later than 15 days following the Receipt of the Claim. The Claims Administrator may extend this 15-day period, however, for up to 15 additional days if (a) such an extension is necessary due to matters beyond the control of the Plan, *and* (b) the Claimant is notified of the extension prior to the expiration of the original 15-day period. A situation that is beyond the control of the Plan includes, but is not limited to, a situation in which the Claimant fails to submit information that is necessary to decide a Claim. The Claims Administrator shall notify the Claimant in writing of the decision that was made on the Pre-Service Claim.

Section A.23 Deadline for Filing Appeal of Adverse Benefit Determination on Pre-Service Claim. The Claimant shall have 180 days following the Receipt of a notice of an Adverse Benefit Determination of a Pre-Service Claim to file an Appeal. Any Appeal shall be filed with the Claims Administrator in writing.

Section A.24 Procedures for Appealing Adverse Benefit Determination of Pre-Service Claim. In any Appeal of an Adverse Benefit Determination on a Pre-Service Claim, the following procedures shall be observed:

(a) The Claimant shall have the right to present evidence and written testimony as part of the Appeal process;

(b) The evaluation of the Claimant's Appeal shall take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was submitted or considered in the initial benefit determination;

(c) The Claims Administrator shall designate an appropriate individual or individuals to consider the Appeal. The individual(s) considering the Appeal shall not be the same individual(s) who originally decided the Claim nor shall they be subordinates of the individual(s) who originally decided the Claim;

(d) In considering the Appeal, no deference shall be given to the initial Adverse Benefit Determination;

(e) If the initial Adverse Benefit Determination was based on the Claim being not Medically Necessary or constituting Experimental or Investigational treatment, or some similar exclusion or limit, the individual(s) considering the Appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional who is consulted for this purpose shall not have been involved with or consulted regarding the initial Adverse Benefit Determination nor shall such a professional be a subordinate of any professional who was involved with or consulted regarding the initial Adverse Benefit Determination;

(f) If the Claims Administrator has considered, relied upon, or generated any new or additional evidence in denying the Claimant's Appeal, the Claimant must be advised of his/her right to receive, free of charge, a copy of such new or additional evidence and his/her right to respond in writing; and

(g) In connection with the Appeal, the Claims Administrator must identify any medical or vocational experts whose advice was obtained on behalf of the plan in making the initial Adverse Benefit Determination, regardless of whether such advice was relied upon in making the initial Adverse Benefit Determination.

Section A.25 Deadline for Deciding Appeal of Denial of Pre-Service Claim. An Appeal of an Adverse Benefit Determination on a Pre-Service Claim shall be decided within 30 days following the Claims Administrator's Receipt of the Claimant's request for the Appeal. The Claims Administrator shall notify the Claimant in writing of the decision made on his/her Appeal of the Adverse Benefit Determination of the Pre-Service Claim.

PART IV – CONCURRENT CARE DECISIONS

Section A.26 Definition of Concurrent Care Decision. A Concurrent Care Decision is a decision by the Plan to reduce, terminate, or refuse to extend an ongoing course of treatment (for which pre-approval is required and was previously granted) which is to be provided over a specified period of time or for a specified number of treatments. All Concurrent Care Decisions constitute Adverse Benefit Determinations.

Section A.27 Notification Regarding Concurrent Care Decisions by Plan Involving Reduction or Termination of Covered Treatment. Any reduction or termination by the Plan of an approved, ongoing course of treatment before the end of the approved period of time or number of treatments is an Adverse Benefit Determination. Notification of such a Concurrent Decision shall be given to a Covered Person sufficiently in advance of the reduction or termination of the course of treatment to allow him/her to Appeal and to obtain a determination on review of that Adverse Benefit Determination before it takes effect.

Section A.28 Requested Extension of Course of Treatment. The following rules apply if a Claimant requests an extension of a course of treatment (for which pre-approval is required and was previously granted) beyond the period of time or number of treatments that have been previously approved:

(a) If the course of treatment involves Urgent Care (as defined in Section A.07), the request shall be decided as soon as possible, taking into account the medical exigencies. If the request was received at least 24 hours prior to the expiration of the approved course of treatment, the Claims Administrator shall notify the Claimant of its decision on the Claim no more than 24 hours after Receipt of the request. If the request was not Received at least 24 hours prior to the expiration of the approved course of treatment, the Claims Administrator shall notify the Claimant of its decision on the Claim no more than 72 hours after Receipt of the request.

(b) If the course of treatment does not involve Urgent Care, the request will be treated as a Pre-Service Claim and shall be decided within the time frame applicable to Pre-Service Claims (as set forth in Section A.25).

Section A.29 Deadline for Filing an Appeal of a Concurrent Care Decision. Although a Claimant is strongly encouraged to file any Appeal of an Adverse Benefit Determination on a Concurrent Care Decision as soon as possible, the Claimant shall have up to 180 days following his/her Receipt of the Adverse Benefit Determination to file the Appeal. Any Appeal shall be filed with the Claims Administrator.

Section A.30 Procedures for Appealing Adverse Benefit Determination of Concurrent Care Decision. In any Appeal of an Adverse Benefit Determination involving a Concurrent Care Decision, the following procedures shall be observed:

(a) If requested by the Claimant, the Claims Administrator may permit the Claimant to submit – where feasible – any information relevant to his/her Appeal either orally or in writing in order to expedite the processing and consideration of the Appeal. Where such expedited processing is necessary and appropriate, any information relevant to the Appeal may be transmitted between the Claims Administrator and the Claimant by telephone, facsimile, electronic mail, or similar delivery method;

(b) The Claimant shall have the right to present evidence and written testimony as part of the Appeal process;

(c) The evaluation of the Claimant's Appeal shall take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) The Claims Administrator shall designate an appropriate individual or individuals to consider the Appeal. The individual(s) considering the Appeal shall not be the same individual(s) who originally decided the Claim nor shall they be subordinates of the individual(s) who originally decided the Claim;

(e) In considering the Appeal, no deference shall be given to the initial Adverse Benefit Determination;

(f) If the initial Adverse Benefit Determination was based on the Claim being not Medically Necessary or constituting Experimental or Investigational treatment, or some similar exclusion or limit, the individual(s) considering the Appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional who is consulted for this purpose shall not have been involved with or consulted regarding the initial Adverse Benefit Determination nor shall such a professional be a subordinate of any professional who was involved with or consulted regarding the initial Adverse Benefit Determination;

(g) If the Claims Administrator has considered, relied upon, or generated any new or additional evidence in denying the Claimant's Appeal, the Claimant must be advised of his/her right to receive, free of charge, a copy of such new or additional evidence and his/her right to respond in writing; and

(h) In connection with the Appeal, the Claims Administrator must identify any medical or vocational experts whose advice was obtained on behalf of the plan in making the initial Adverse Benefit Determination, regardless of whether such advice was relied upon in making the initial Adverse Benefit Determination.

Section A.31 Deadline for Deciding Appeal of Concurrent Care Decision. An Appeal of a Concurrent Care Decision (which is, by definition, an Adverse Benefit Determination) shall be decided, as applicable, within the time frame governing either Urgent Care Claims (as set forth in Section A.16) or Pre-Service Claims (as set forth in Section A.25). The Claims Administrator shall notify the Claimant in writing of the decision made on his/her Appeal of a Concurrent Care Decision.

PART V – POST-SERVICE CLAIMS

Section A.32 Definition of Post-Service Claim. A Post-Service Claim is a Claim that is submitted after the underlying medical care or treatment has already been provided. Please note that a Pre-Service Claim (as defined in Section A.17) that was approved in accordance with the provisions applicable to Pre-Service Claims or an Urgent Care Claim (as defined in Section A.07) that was approved in accordance with the procedures applicable to Urgent Care Claims will be treated as a Post-Service Claim once the underlying medical care or treatment has been provided and will, at that point, be subject to the provisions of the Plan that apply to Post-Service Claims. The Claims Administrator will not deny

coverage for any medical care or treatment that had previously been approved under the procedures applicable to Pre-Service Claims or Urgent Care Claims.

Section A.33 **How to File a Post-Service Claim.** Claims must include the following information:

(a) The name and address of the Claimant for whom the expense was incurred and, if such person is not the Employee (or covered class member) requesting the benefit, the relationship of such Claimant to the Employee (or covered class member);

(b) The name and address of the Employee (or covered class member);

(c) The Plan's group number;

(d) The identity of the Employee's (or covered class member's) Employer;

(e) The name, address, telephone number, and tax ID number of the service provider to whom the payment is to be made;

(f) The amount, date, and nature of each expense, along with any corresponding diagnosis and service codes;

(g) A statement that the expense (or portion thereof for which reimbursement is sought under the Plan) may be reimbursable under some other plan coverage; and

(h) Any other information relating to the medical care or treatment in question that is relevant and that should be considered in evaluating the Claim.

Section A.34 **Time Period for Filing Post-Service Claims.** Claims must be filed within 365 days after the charge for the particular medical care or treatment was incurred by the Covered Person. A Claim that is not filed within this time period will be denied or reduced. (Please note that this time period is the deadline to file the initial Claim. This initial submission is typically handled by the medical service provider. The deadline for filing an appeal of a post-service is set forth in Section A.38 below.)

Section A.35 **Failure to Submit Necessary Information.** If the Claimant fails to submit information that is necessary to process a Post-Service Claim, the Claims Administrator shall notify the Claimant of such failure within 30 days following the Receipt of the Claim and shall identify the specific information that is necessary to complete the Claim.

(a) Upon Receipt of such notification, the Claimant shall have 45 days to provide the requested information to the Claims Administrator.

(b) During the period between the date the additional information is requested and the date it is received by the Claims Administrator, the deadline for deciding the Claim, as set forth in Section A., shall be suspended.

(c) Following Receipt of the additional information that was requested by the Claims Administrator, the Claims Administrator shall decide the Claim within the number of days that were remaining in the original 30-day period (as extended) as of the date the additional information was requested.

(d) If the requested information is not received by the Claims Administrator within 45 days after the Claimant Received the Claims Administrator's request for such information, the Claims Administrator shall deny the Claim.

Section A.36 Deadline for Deciding a Post-Service Claim. Following the submission of a Post-Service Claim that has been filed in accordance with the provisions of this Article, the Claims Administrator shall decide the Post-Service Claim not later than 30 days following the Receipt of the Claim. The Claims Administrator may extend this 30-day period, however, for up to 15 additional days if (a) such an extension is necessary due to matters beyond the control of the Plan, *and* (b) the Claimant is notified of the extension prior to the expiration of the original 30-day period. A situation that is beyond the control of the Plan includes, but is not limited to, a situation in which the Claimant fails to submit information that is necessary to decide a Claim.

Section A.37 Notification Regarding Initial Adverse Benefit Determination on Post-Service Claim. The Claims Administrator shall notify the Claimant in writing of the decision that was made on the Post-Service Claim. If the Claim was denied in whole or in part – which is considered an Adverse Benefit Determination – the notice provided to the Claimant shall be written in a manner calculated to be understood by the Claimant.

Section A.38 Deadline for Filing Appeal of Adverse Benefit Determination on Post-Service Claim. The Claimant shall have 180 days following the Receipt of a notice of an Adverse Benefit Determination of a Post-Service Claim to file an Appeal. Any Appeal shall be filed with the Claims Administrator in writing.

Section A.39 Procedures for Appealing Adverse Benefit Determination of Post-Service Claim. In any Appeal of an Adverse Benefit Determination on a Post-Service Claim, the following procedures shall be observed:

(a) The Claimant shall have the right to present evidence and written testimony as part of the Appeal process;

(b) The evaluation of the Claimant's Appeal shall take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was submitted or considered in the initial benefit determination;

(c) The Claims Administrator shall designate an appropriate individual or individuals to consider the Appeal. The individual(s) considering the Appeal shall not be the same individual(s) who originally decided the Claim nor shall they be subordinates of the individual(s) who originally decided the Claim;

(d) In considering the Appeal, no deference shall be given to the initial Adverse Benefit Determination;

(e) If the initial Adverse Benefit Determination was based on the Claim being not Medically Necessary or constituting Experimental or Investigational treatment, or some similar exclusion or limit, the individual(s) considering the Appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional who is consulted for this purpose shall not have been involved with or consulted regarding the initial Adverse

Benefit Determination nor shall such a professional be a subordinate of any professional who was involved with or consulted regarding the initial Adverse Benefit Determination;

(f) If the Claims Administrator has considered, relied upon, or generated any new or additional evidence in denying the Claimant's Appeal, the Claimant must be advised of his/her right to receive, free of charge, a copy of such new or additional evidence and his/her right to respond in writing; and

(g) In connection with the Appeal, the Claims Administrator must identify any medical or vocational experts whose advice was obtained on behalf of the plan in making the initial Adverse Benefit Determination, regardless of whether such advice was relied upon in making the initial Adverse Benefit Determination.

Section A.40 Deadline for Deciding Appeal of Denial of Post-Service Claim. An Appeal of an Adverse Benefit Determination on a Post-Service Claim shall be decided within 60 days following the Claims Administrator's Receipt of the Claimant's request for the Appeal. The Claims Administrator shall notify the Claimant of the decision made on his/her Appeal of the Adverse Benefit Determination of the Post-Service Claim.

PART VI – RESCISSION OF COVERAGE

Section A.41 Definition of Rescission of Coverage. A "Rescission of Coverage" refers to the Plan's total rescission of a Claimant's coverage under the Plan on the basis of fraud or misrepresentation.

Section A.42 Notice of Rescission. In the case of a Rescission of Coverage, the Plan must provide notice to a Covered Person of the rescission of his/her coverage at least 30 days prior to the effective date of the rescission. This notice serves as an Adverse Benefit Determination.

Section A.43 Deadline for Filing an Appeal. The Claimant shall have 180 days following the Receipt of a notice of a Rescission of Coverage to file an Appeal. Any Appeal shall be filed with the Claims Administrator in writing.

Section A.44 Required Procedures In Connection with Filing and Deciding Appeal of Rescission of Coverage. The procedures for a Claimant to Appeal a Rescission of Coverage, and the Claims Administrator's deadline for deciding such an Appeal, shall be the same as those that govern Post-Service Claims, as set forth in Sections A.39-A.40.

PART VII – EXTERNAL REVIEW PROCESS

If a Claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, the Claimant may (but does not have to) request that the Claim be reviewed under the Plan's External Review process. As described in detail below, the External Review process entails a review of the Claim by an independent third-party organization.

Section A.45 Deadline for Requesting External Review of Final Adverse Benefit Determination. A request for External Review of a Final Adverse Benefit Determination must be filed by the Claimant or his/her authorized representative in writing within four (4) months after Receipt of the Final Adverse Benefit Determination.

Section A.46 Determination Whether Claim is Eligible for External Review. Within five (5) days after receiving a Claimant's request for External Review, the Plan Administrator shall determine whether the Claim is eligible for review under the External Review process. This determination is based on whether:

(a) The Claimant is/was covered under the Plan at the time the Claim was made or incurred;

(b) The denial relates to the Claimant's failure to meet the Plan's eligibility requirements. (If the Claim involves an eligibility issue, External Review is not available);

(c) The Claimant has exhausted the Plan's internal Claims and Appeal procedures; and

(d) The Claimant has provided all the information required to process an External Review.

Within one (1) business day after completion of this preliminary review, the Claims Administrator will provide written notification to the Claimant of whether the Claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Claims Administrator will notify the Claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the Claims Administrator's notice will describe the information needed to complete it. The Claimant will have 48 hours or until the last day of the 4-month filing period, whichever is later, to submit the additional information.

Section A.47 Assignment to Independent Review Organization for External Review. If the Claimant's request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the Claimant, in writing, that the request for External Review has been accepted. The notice will include a statement that the Claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

Section A.48 Evaluation of Claim by IRO. If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(a) The Claimant's medical records;

(b) The attending health care professional's recommendation;

(c) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, Claimant, or the Claimant's treating provider;

(d) The terms of the Plan;

(e) Appropriate practice guidelines;

(f) Any applicable clinical review criteria developed and used by the Plan; and

(g) The opinion of the IRO's clinical reviewer.

Section A.49 Claim Decision by IRO. The IRO must provide written notice to the Plan and the Claimant of its final decision within 45 days after the IRO receives the request for the External Review.

Section A.50 Availability of Expedited External Review. Generally, a Claimant must exhaust the Plan's Claims and Appeal procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review. Expedited External Review is available if either of the following two conditions is satisfied:

(a) *Requiring Appeal of Adverse Benefit Determination Under Plan's Internal Claims and Appeal Procedure Timetable Would Seriously Jeopardize Claimant's Life or Health*. The Claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal procedures would seriously jeopardize the Claimant's life or health or ability to regain maximum function and the Claimant has filed a request for an expedited internal review; or

(b) *Final Adverse Benefit Determination Involves Emergency Services and Claimant Remains Hospitalized*. The Claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the Claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO.

The IRO must then make its determination and provide a notice of the decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours.

MEDICAL • PRESCRIPTION DRUG • DENTAL

BENEFIT DESCRIPTION

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Do you know that your group health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? In the case of a Covered Person who is receiving benefits in connection with a mastectomy, coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to the annual Deductible and Co-Insurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

Contact the Claims Administrator for more information: Benefit Management, LLC, PO Box 1090, Great Bend, Kansas 67530, (800) 290-1368.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Claims Administrator.

LIVINGCONNECTED PROGRAM

The Plan will provide 100% reimbursement for diabetes testing supplies when obtained through the **LivingConnected Program** managed by MedWatch & CCS Medical, (DEGC Enterprises U.S., Inc.) and Benefit Management, LLC. Members will not have any Co-Payments, Deductible or Co-Insurance through this exclusive program.

Program participants receive the following exclusive benefits:

- Access to an innovative new mobile health solution that incorporates an easy to use cellular-enabled glucose meter along with patient tools, care team portals, and advanced self-management support and coaching.
- Instant feedback and support provided to the member via 2-way messaging and alerts sent directly to the wireless glucose meter.
- Live call center monitoring and intervention.
- Coaching from a Registered Nurse when your readings are out of range.
- 24/7/365 toll-free access to live Nursing Support
- Award winning mobile applications and a member educational library.
- **Coverage for the following diabetic testing supplies at no cost to you:**
    - **Cellular-enabled wireless glucose meter**
    - **Glucose Meter Starter Kit**
    - **Control solution**
    - **Lancing device(s)**
    - **Lancets**
    - **Automatic Refills based on your Testing Frequency mailed directly to your home**

Participation in the **LivingConnected Program** is voluntary. Diabetic testing supplies obtained outside the **LivingConnected Program** will continue to be eligible expenses under this Plan; however, they do not qualify for the program's 100% no cost-sharing benefit. This means you may experience higher out-of-pocket costs if you purchase supplies from another vendor, provider, pharmacy or supplier.

Persons who utilize an insulin pump where the pump and glucose meter communicate wirelessly and the glucose meter manages the amount of insulin dispensed by the pump will not qualify and should continue to utilize their current insulin pump and supplies.

To Learn More

Contact **CCS Medical Customer Support** team at **1(800) 274-1853** to speak to the **Benefit Management** dedicated team and for more information about how you can join this exclusive program and receive services and supplies to help manage a diabetic condition.

PRESCRIPTION SAVINGS PROGRAM

The Plan has entered into a direct agreement with PriceMDs.com to offer cost-saving opportunities on certain high-cost medications when purchased through Health City Cayman Islands ("HCCI"). The Prescription Savings Program is a voluntary program that delivers savings to the Covered Person and the Plan. This program is not intended to reduce or otherwise deny a Covered Person benefits for treatment of a medical condition otherwise eligible under the Plan. Covered Persons may choose to participate but they are not required to participate.

Prescription Drug Deductible and Prescription out-of-pocket maximum are waived for medications purchased through the Prescription Savings Program.

To qualify:

1. The medication must be available through the Prescription Savings Program;
2. The medication must be pre-certified and approved through Utilization Management;
3. The medication must be administered or supplied through HCCI;
4. The necessary travel arrangements must be obtained through HCCI's patient concierge; and

The medication:

1. Must be deemed Medically Necessary to treat the condition for which it is being prescribed;
2. Must not be Experimental or Investigational, as defined by the Plan;
3. Must have received final approval from the U.S. Food and Drug Administration for the lawful marketing of the Regimens for the specific Injury or Illness to be treated; and
4. Must not be excluded or limited under an exclusion or limitation of the Plan.

The Plan will not exclude the medication as non-FDA approved based solely on the drug being supplied through HCCI. Contact the Claims Administrator at (800) 290-1368 for more information about the program and provisions of the Plan.

PART I - SCHEDULE OF BENEFITS

VERIFICATION OF ELIGIBLITY

Call the number below to verify eligibility for Plan benefits **before** the charge is incurred.

Verification of Eligibility (800) 290-1368

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including - but not limited to - the Plan Administrator's determination that: care and treatment is Medically Necessary; charges are the Allowed Amount; services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: The following services must be pre-certified or reimbursement from the Plan may be reduced.

Hospitalization	**Inpatient Substance Abuse Treatments**
Skilled Nursing Facility stays	**Inpatient Mental Disorder Treatments**

After 48 observation hours, a confinement will be considered an Inpatient confinement. Observations in excess of 48 hours require pre-certification as an Inpatient stay. Pre-certification penalties may apply if observation exceeds 48 hours.

See the Cost Management section in this booklet for details. You will need to follow these sections or reimbursement from the Plan may be reduced. The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Please read the section Alternate Treatment in the Dental Plan. You will need to follow this section or reimbursement from the Plan may be reduced.

PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK AND NON-NETWORK PROVIDERS

KANSAS EMPLOYEES

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers in the **ProviDRs Care Network,** called Network Providers, who have agreed to certain reduced fees. A list of providers in the Plan's PPO Network is available free-of-charge by contacting the PPO via telephone or by visiting the PPO's website. Refer to the Covered Person's Plan identification card for the PPO Network's phone number and website address. PPO Network providers are subject to change without notification.

When a Covered Person uses a PPO Network provider that Covered Person will receive better benefits from the Plan than when a Non-Network provider is used. It is the Covered Person's choice as to which provider to use; however, reimbursement is at the highest level when services are provided by a PPO Network provider.

In order for the claim to be appropriately filed, it is important that the provider of service have the most current identification card. It is the patient's responsibility to confirm the most current card is on file with the provider.

Out-of-Area Network

The Plan is a plan which contains an Out-of-Area Network (sometimes referred to as a "travel network"). The Out-of-Area Network, **First Health Network**, is available for Covered Persons who seek healthcare services

outside of the PPO service area. For purposes of the Plan, the state of Kansas is designated as the PPO service area. When an individual receives services outside the PPO service area by an Out-of-Area Network provider, the Covered Charges are considered at the PPO Network level of benefits. A list of providers in the Plan's Out-of-Area Network is available free-of-charge by contacting the Out-of-Area Network via telephone or by visiting the Out-of-Area Network's website. Refer to the Covered Person's Plan identification card for the phone number and website address. The Out-of-Area Network providers are subject to change without notification.

EMPLOYEES OUTSIDE OF THE STATE OF KANSAS

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers in the **First Health Network,** called Network Providers, who have agreed to certain reduced fees. A list of providers in the Plan's PPO Network is available free-of-charge by contacting the PPO via telephone or by visiting the PPO's website. Refer to the Covered Person's Plan identification card for the PPO Network's phone number and website address. PPO Network providers are subject to change without notification.

When a Covered Person uses a PPO Network provider that Covered Person will receive better benefits from the Plan than when a Non-Network provider is used. It is the Covered Person's choice as to which provider to use; however, reimbursement is at the highest level when services are provided by a PPO Network provider.

In order for the claim to be appropriately filed, it is important that the provider of service have the most current identification card. It is the patient's responsibility to confirm the most current card is on file with the provider.

BENEFIT UPGRADE

Under the following circumstances, the higher PPO Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of PPO Network Providers in the specialty that the Covered Person is seeking within the PPO service area. Additionally, benefits will be upgraded to the PPO Network level in limited situations when the Claims Administrator determines the PPO provider availability is insufficient and a person would be required to travel more than 50 miles to seek services.

If a Covered Person receives services from a Municipal Health Department.

If a Covered Person has a Medical Emergency or is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Network Physician or Medical Care Facility refers x-ray and laboratory services to a Non-Network provider.

If a Non-Network assistant surgeon performs services in a Network Facility.

If a Covered Person receives Physician or anesthesia services by a Non-Network Provider at a Network facility.

If a Covered Person has no choice for purchasing Medical/Surgical Supplies and Durable Medical Equipment through a Network Provider.

If you receive services from a Non-Network Provider, the provider may bill you for amounts in excess of the Allowed Amount. Payment of the balanced billed amount is the responsibility of the Covered Person.

Medical and Dental Benefits are independent. If medical coverage is desired, you must elect medical coverage on the enrollment form that is provided to you by the Plan Administrator. If you do not elect medical coverage, you are not a Covered Person for Medical Benefits.

MEDICAL BENEFITS SCHEDULE

BENEFIT CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM BENEFIT AMOUNT:	Unlimited	
DEDUCTIBLE PER BENEFIT YEAR		
Per Covered Person	$700	
Per Family Unit	$1,400	
CO-INSURANCE PERCENTAGE PAYABLE		
Percentage Payable by the Plan	80%	60%
CO-INSURANCE OUT-OF-POCKET MAXIMUM PER BENEFIT YEAR		
Per Covered Person	$1,000	$2,000
Per Family Unit	$2,000	$4,000
TOTAL OUT-OF-POCKET PER BENEFIT YEAR Deductible + Co-Insurance		
Per Covered Person	$1,700	$2,700
Per Family Unit	$3,400	$5,400

IMPORTANT NOTES ABOUT DEDUCTIBLES AND CO-INSURANCE OUT-OF-POCKET MAXIMUM

- Network and Non-Network Co-Insurance out-of-pocket maximums accumulate together.
- The following charges do not apply toward the Deductible or Co-Insurance out-of-pocket maximum and are never paid at 100%.
  - Co-Payments
  - Cost containment penalties
  - Amounts over the Allowed Amount
- Prescription Drug Card expenses do not apply to the Medical Deductible or Co-Insurance out-of-pocket.
- After satisfaction of the Deductible, the Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, then the Plan will pay 100% of the Covered Charges for the remainder of the Benefit Year unless stated otherwise.

COVERED CHARGES

Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed under a service, the Benefit Year maximum is 60 days total which may be split between Network and Non-Network providers.

BENEFIT CATEGORY	PLAN PAYS	PLAN PAYS
Hospital Services (Inpatient)		
Room and Board Payment rate is the semiprivate room rate; or Hospital's ICU charge for Intensive Care Unit admission	80% after Deductible	60% after Deductible
Emergency Room Visit		
Medical Emergency or Non-Emergency Includes services billed with an emergency room place of service	80% after Deductible	
Urgent Care Facility Includes services billed with an urgent care place of service or services billed by an urgent care facility as an office visit.	80% after Deductible	60% after Deductible

BENEFIT CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Ambulatory Surgical Center/ Outpatient Hospital Surgery Facility/ Other Freestanding Outpatient Surgical Facility	80% after Deductible	60% after Deductible
Skilled Nursing Facility Benefit Year maximum limit: 60 days	80% after Deductible	60% after Deductible
Physician Services		
Inpatient visits	80% after Deductible	60% after Deductible
Primary Care Office Visits	80% after Deductible	60% after Deductible
Specialist Office Visits	80% after Deductible	60% after Deductible
Walk-in Retail Health Clinic/Convenience Care	80% after Deductible	60% after Deductible
Surgery/ Anesthesia (Inpatient or Outpatient)	80% after Deductible	60% after Deductible
Allergy testing, injections, serum and antigens	80% after Deductible	60% after Deductible
Spinal Manipulation/ Chiropractic Care Benefit Year maximum limit: 30 visits	80% after Deductible	60% after Deductible
Outpatient Diagnostic Testing	80% after Deductible	60% after Deductible
Home Health Care	80% after Deductible	60% after Deductible
Hospice Care (Includes Bereavement Counseling)	80% after Deductible	60% after Deductible
Ambulance Service	80% after Deductible	
Durable Medical Equipment	80% after Deductible	60% after Deductible
Hearing Aids • One hearing aid per ear every three (3) Benefit Years limited to $1,500 per aid. • Four additional ear molds per Benefit Year up to two (2) years of age. *(See "Part II Medical Benefits-Audiology Services" for a complete description of this benefit.)*	80% after Deductible	
Medical/Surgical Supplies	80% after Deductible	60% after Deductible
Outpatient Rehabilitation Services		
Occupational Therapy	80% after Deductible	60% after Deductible
Physical Therapy	80% after Deductible	60% after Deductible
Speech Therapy	80% after Deductible	60% after Deductible
Cardiac Rehabilitation	80% after Deductible	60% after Deductible
Pulmonary Rehabilitation	80% after Deductible	60% after Deductible
Respiratory Therapy	80% after Deductible	60% after Deductible
Neuropsychological Testing	80% after Deductible	60% after Deductible

BENEFIT CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Orthotics	80% after Deductible	60% after Deductible
Prosthetics	80% after Deductible	60% after Deductible
Mental Disorders and Substance Abuse Treatments		
Inpatient	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
Preventive Care Services		
Preventive Adult Care Services Employee and Covered Spouse only Preventive Care includes, but is not limited to, such services as an annual exam, Pap smear gynecological exam, mammogram, PSA and prostate screening, colorectal cancer screening, stress tests, bone density scan, hearing exam and preventive x-ray and lab screenings.	First $400 per Benefit Year paid at 100% by the Plan Thereafter, Participant pays: 20% after Deductible Plan pays: 80% after Deductible	60% after Deductible Maximum payable per Benefit Year: $400
Immunizations – All ages	100%, Deductible waived	60% after Deductible
Preventive Child Care Services Dependent Children under age 16 Preventive Care includes: office visits, routine physical exam, laboratory tests, and routine x-rays.	First $400 per Benefit Year paid at 100%, by the Plan Thereafter; Participant Pays: 20% after Deductible Plan Pays: 80% after Deductible	60% after Deductible Maximum payable per Benefit Year: $400
Preventive Eye Exam (Includes refractions) Benefit Year maximum limit: one (1) exam Excludes Hardware	100%, Deductible waived	
Preventive Hearing Exam Benefit Year maximum limit: one (1) exam	See Preventive Adult Care Services	
Surgical Sterilization (Reversals Excluded)	80% after Deductible	60% after Deductible
Organ Transplants Pre-certification required Must be received in a Designated Transplant Facility.	80% after Deductible	Not Covered

BENEFIT CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Pregnancy	80% after Deductible	60% after Deductible
Pregnancy benefits include prenatal, delivery, and post-partum care. Services are for routine Pregnancy and complications of Pregnancy. The newborn child is only covered under the Plan if enrolled in the Plan within 63 days from the date of birth. If you do not add your newborn to the Plan, the cost of the baby's Hospital Inpatient stay and any other costs incurred after delivery are not Covered Charges under the Plan.		
Newborn Nursery Care (Care while the newborn is confined after birth. Charged to the Plan of the newborn.) *The newborn child is only covered under the Plan if enrolled in the Plan within 63 days from the date of birth. If you do not add your newborn to the Plan, the cost of the baby's Hospital Inpatient stay and any other costs incurred after delivery are not Covered Charges under the Plan.*	80% after Deductible	60% after Deductible
All Other Covered Charges	80% after Deductible	60% after Deductible

PRESCRIPTION DRUG CARD
BENEFITS SCHEDULE

PRESCRIPTION DRUG CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
	COVERED PERSON PAYS:	PLAN PAYS:
PRESCRIPTION DRUG DEDUCTIBLE, PER BENEFIT YEAR		
Per Covered Person	$100	
Per Family Unit	$200	
Deductibles for Prescription Drugs do not apply toward the medical out-of-pocket maximums.		
MAXIMUM PRESCRIPTION OUT-OF-POCKET, PER BENEFIT YEAR (Excluding Prescription Deductible)		
Per Covered Person	$2,000	
Per Family Unit	$4,000	
Prescription Drug out-of-pocket maximums do not apply toward the medical out-of-pocket maximums.		
	PARTICIPANT PAYS	**PLAN PAYS**
Pharmacy Option (Up to a 34-day supply)		
Generic Drugs	$10 Co-Payment, prescription Deductible waived	Reimbursement is at the Network Allowed Amount for the drug. You may have higher out-of-pocket expenses if you use a Non-Participating Pharmacy.
Brand Name Drugs	20% of the Allowed Amount after prescription Deductible has been satisfied	
Maintenance Medications - Mail Order or Performance 90 Pharmacy (Up to a 90-day supply)		
Generic Drugs	$10 Co-Payment, prescription Deductible waived	Not Available
Brand Name Drugs	20% of the Allowed Amount after prescription Deductible has been satisfied	

Tobacco Deterrents are Covered Charges by prescription only. Limitations may apply. The deterrents are subject to the prescription Deductible, appropriate Co-Payment and prescription out-of-pocket limit.

Generic Program

If a Generic equivalent is available, then that equivalent is the benefit. If the patient, for whatever reason, demands the more expensive branded product be dispensed, the patient pays in addition to the appropriate Co-Pay, the difference in cost between the Generic and Brand Name Drugs. The difference in cost will not be used to satisfy any out-of-pocket maximum amount.

Generic Plus Programs

First-Fill-Free

MedTrak offers a first-fill-free program which allows individuals to obtain a first fill medication of select Generic Drugs at $0 Co-Pay. When you purchase a medication for the first time, ask your pharmacist if the Brand Name Drug is eligible for the first-fill-free program. This program allows an individual to try a lower costing, but effective, Generic Drug that will save on out-of-pocket costs.

Co-Pay Waiver

MedTrak offers a Co-Pay waiver program which allows individuals to obtain up to a six (6) month supply of select Generic Drugs at a $0 Co-Pay. If you are prescribed a Brand Name Drug and you are interested in trying a lower costing Generic Drug, ask your pharmacist if the medication is eligible for the Co-Pay waiver program.

ScriptChoice and eScriptChoice

These programs are available as part of the MedTrak Right Choice Program and are a valuable resource for Covered Persons. **ScriptChoice** is a direct mail program that informs members about available savings on select drug options. **eScriptChoice** is an on-line resource which is an education tool about lower costing drug alternatives.

Step Therapy Program

The Step Therapy Program encourages safe and cost-effective medication use. Under this program, a "step" approach is utilized for certain high-cost medications. To receive the benefit, the Covered Person may be directed to first try a proven cost-effective medication before using a more costly treatment, if possible. However, treatment decisions are always between the patient and the patient's Physician.

Drug categories which may be included in the Step Therapy Program are medications such as Alpha-Blockers, Blood Pressure, Diabetes medication, High Cholesterol, Depression, Acid Reflux, Acne, Proton Pump Inhibitors and more. For a specific list of Step Therapy Program medications contact MedTrak Services at the number listed on the Covered Person's ID card.

The Step Therapy Program requires the Covered Person to have a prescription history for a "first-step" medication before the Plan will cover a "second-step" drug. A first-step drug is recognized as safe and effective in treating a specific medical condition, as well as being cost-effective. A second-step drug is a less-preferred or sometimes more costly treatment option.

Step 1 – Whenever possible, the Physician should prescribe a first-step medication that is appropriate for treatment of the medical condition.

Step 2 – If the Physician determines that the first-step drug is not appropriate or is not effective, the Plan will cover a second-line drug when certain conditions are met. The Pharmacy and the Covered Person's Physician will work with MedTrak Services to obtain prior authorization for second-step medications.

Maintenance Medications

Performance 90 Program

Select retail Pharmacies in the MedTrak Network are designated as Performance 90 Pharmacies. These Pharmacies provide 90-day fills for maintenance medications (those that are taken for long periods of time) at reduced costs. When purchasing maintenance medications from a retail Pharmacy, use a Performance 90 Pharmacy to obtain the lowest cost and greater out-of-pocket savings. Contact MedTrak Services via phone

at (800) 771-4648, or use their on-line look-up at www.medtrakrx.com, to locate Performance 90 Pharmacies near you.

Mail Order Drug Benefit

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time). Purchasing medications through the mail is easy, convenient and offers the best discounted price. For instruction on how to purchase Prescription Drugs through the Mail Order program or online, refer to the prescription packet provided at enrollment, visit the Pharmacy Benefit Manager's website, or contact them via phone for more information.

90/91 Day Packaged Products at Retail

Certain medications are packaged and sold in 90/91 day supplies. These medications - usually contraceptives and 90-day Estrogen - are subject to one Co-Payment for each 90-day supply. Generic contraceptives are covered at 100% without cost-sharing when purchased at a Network Pharmacy.

Vaccines

Certain Pharmacies in the MedTrak Services Network administer vaccines and such vaccines are Covered Charges without cost-sharing. The type of vaccine available is limited; talk to your Pharmacy to learn more about its vaccine capabilities. Contact MedTrak Services at the phone number listed on the Covered Person's identification card to find out which Pharmacies participate in the MedTrak Services Network.

Specialty Drugs

Specialty Drugs means high-cost, complex pharmaceuticals (usually injectable) that have unique clinical, administration, distribution, or handling requirements that are not commonly available in traditional community and mail-order Pharmacies. Contact MedTrak for a ***Best In Class Specialty Pharmacy Network***.

Non-Network Pharmacies

After obtaining a prescription at a non-network pharmacy or failing to show your ID card at a participating pharmacy, you may be required to submit a claim to obtain reimbursement. If so, you must obtain a Pharmacy claim form from the Pharmacy Benefit Manager, complete the form, and submit it - along with the prescription receipt - to the Pharmacy Benefit Manager. The Pharmacy Benefit Manager will process the claim and reimburse you in accordance to the Plan.

The Allowed Amount is limited to the Network Allowed Amount. You may have higher out-of-pocket costs if a Prescription Drug is purchased from a Non-Network provider. The amount over the Allowed Amount will not be used to satisfy any out-of-pocket maximum amount.

Contact MedTrak Pharmacy Services at (800) 771-4648 to locate participating Pharmacies, find out more about a specific drug, and how to use the program. This information may also be available at www.medtrakrx.com.

DENTAL BENEFITS SCHEDULE

Medical and Dental Benefits are independent. If dental coverage is desired, you must elect dental coverage on the enrollment form that is provided to you by the Plan Administrator. If you do not elect dental coverage, you are not a Covered Person for Dental Benefits.

DEDUCTIBLE PER BENEFIT YEAR	
Per Covered Person	$50
Per Family Unit	$100
Deductible applies to Class II - Basic Services and Class III Major Services	
BENEFIT CATEGORY	**PERCENTAGE PAYABLE BY THE PLAN**
Class I Services – Preventive	100%
Class II Services – Basic	80%
Class III Services – Major	50%
Note: No benefits are payable for Class III – Major Services in the first 8 months of the Covered Person's coverage under the Plan.	
Class IV Services – Orthodontia	Not Covered
MAXIMUM AMOUNT PAYABLE PER BENEFIT YEAR	
Per Covered Person Classes I, II and III combined	$1,500
The dental out-of-pocket amount does not accumulate toward the medical out-of-pocket.	

PART II - MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

CO-PAYMENT

A Co-Payment is the amount of money that is paid each time a particular service is used. Typically, there may be Co-Payments on some services and other services will not have any Co-Payments. Co-Payments do not accrue toward the Deductible or Co-Insurance maximum out-of-pocket amount.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Benefit Year a Covered Person must meet the Deductible shown in the Schedule of Benefits. Typically, there is one Deductible amount per Plan. Deductible amounts accrue toward the Total Out-of-Pocket shown in the Schedule of Benefits.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate Deductibles for treatment of injuries incurred in this accident; instead, only one Deductible for the Benefit Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Benefit Year Deductibles, the Deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Benefit Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the Deductible. Payment will be made at the percentages shown in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Each Benefit Year, Covered Charges are payable at the percentages shown in the Schedule of Benefits until the out-of-pocket maximum limit is met. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Benefit Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Benefit Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person for Essential Health Benefits during the Benefit Year.

ORDER OF CLAIMS DETERMINATION

Many times, claims for covered services are not submitted in the same order the covered services are provided. Regardless of the order claims are incurred, the Deductible and percentage payable will be applied to covered services in the sequence that claims are submitted and ready for payment.

COVERED CHARGES

Covered Charges are the Allowed Amounts that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

A. **Hospital Care.** The medical services and supplies furnished by a Hospital, Medical Care Facility, or Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 48 observation hours, a confinement will be considered an Inpatient confinement. Observations in excess of 48 hours require pre-certification as an Inpatient stay. Pre-certification penalties may apply if observation exceeds 48 hours.

Room charges made by a Hospital having only private rooms will be paid at the private room rate.

If a private room is assigned at the Covered Person's request, then the reimbursement is at the semi-private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

B. **Coverage of Pregnancy.** Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a Covered Person.

C. **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

1. the patient is confined as a bed patient in the facility; and

2. the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

3. the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

D. **Physician Care.** The professional services of a Physician for surgical or medical services.

1. Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

2. If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the charge that is allowed for the primary procedures; 50% of the charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

3. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowed Amount for that procedure; and

4. If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 25% of the surgeon's Allowed Amount.

E. **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

1. **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

2. **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

F. **Home Health Care Services and Supplies.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Covered Charges for Home Health Care Services and Supplies are payable as described in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by a nurse or four hours of home health aide services. Therapies are subject to the Outpatient Rehabilitation Services benefit as shown in the Schedule of Benefits.

G. **Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or other covered Dependents). Bereavement services must be furnished within six months after the patient's death.

H. **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

1. Local Medically Necessary professional land or air **ambulance** service as shown in the Schedule of Benefits. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

2. **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

3. **Audiology Services.** Hearing and balance assessment services furnished by a Physician or audiologist. Technicians or other qualified staff may furnish those parts of a service that do not require professional skills under the direct supervision of Physicians. Audiological diagnostic testing refers to tests of the audiological and vestibular systems

including - but not limited to – hearing, balance, auditory processing, tinnitus and diagnostic programming of auditory prosthetics devices. Coverage includes tubing required to properly re-fit a hearing aid due to the person's physiological change and for which a charge is normally made by the provider. See also "Hearing Aids" in the Schedule of Benefits for certain limitations. Batteries are excluded and not covered by the Plan.

Hearing aids are amplifying devices that compensate for impaired hearing. Hearing aids include air conduction devices that provide acoustic energy to the cochlea via stimulation of the tympanic membrane with amplified sound. Cochlear implants, auditory brainstem implants and osseiointegrated implants are prosthetic devices. See also "Prosthetics".

4. **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

5. Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

6. **Clinical Trial.** Regardless of the Experimental and Investigational nature of the Approved Clinical Trial itself, coverage will be provided for all routine patient care costs associated with the provision of healthcare services, including drugs, items, devices, treatments, diagnostics, and services that would otherwise be covered if those drugs, items, devices, treatments, diagnostics and services were not provided in connection with an Approved Clinical Trial program for cancer or other diagnoses that are life threatening or severely and chronically disabling that have failed to respond with conventional treatments. Services covered will include those health care services typically provided to patients not participating in a clinical trial.

   Excluded are:
   - **a.** The costs of the investigational drugs or devices themselves, or the costs of any non-medical services that might be required for the Covered Person to receive the treatment or intervention.
   - **b.** Healthcare services that, except for the fact that they are being provided in a clinical trial are otherwise specifically excluded from coverage under the policy or certificate.
   - **c.** Transportation and/or lodging costs incurred while receiving such treatment.

7. Initial **contact lenses** or glasses required following cataract surgery.

8. **Contraceptive injections and devices** administered in an office setting including Municipal Health Department and family planning clinic. The office visit for planning purposes, fitting, and implantation or administration of the injection or device is included.

9. **Diabetic Supplies, Equipment and Self-Management Programs** as described:

   All Physician prescribed Medically Necessary and appropriate equipment and supplies used in the management and treatment of diabetes; and

   Diabetes Outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for

individuals with gestational, Type I and Type II diabetes.

For Covered Persons with diabetes who have documented peripheral vascular disease and/or peripheral neuropathy, the Plan will cover one (1) pair of orthopedic shoes and two (2) pair of associated shoe inserts per Covered Person per Benefit Year as deemed Medically Necessary and ordered by a Physician.

10. Hemodialysis/Peritoneal **dialysis** treatment of a kidney disorder as an Inpatient in a Hospital or Medical Care Facility, in an Outpatient dialysis facility, or in the Covered Person's home including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or Outpatient dialysis treatments, the Plan will consider rental (or purchase as the case may be) of dialysis equipment and expendable Medical Supplies for use in the Covered Person's home. The dialysis equipment is subject to the Durable Medical Equipment benefit as shown in the Schedule of Benefits. The expendable Medical Supplies are subject to the Medical/Surgical Supplies of the Plan.

11. **Dietary and nutritional counseling** for a medical condition. See also "Diabetic Supplies, Equipment and Self-Management Programs" and "obesity/Morbid Obesity" in this section.

12. Rental of **Durable Medical Equipment** if deemed Medically Necessary subject to the following:

a. The equipment must be prescribed by a Physician and needed in the treatment of an Illness or Injury; and

b. These items may be bought rather than rented. Prior approval is required before the purchase of any Durable Medical Equipment. But in no case will the Plan pay rental past the purchase price (oxygen equipment is not limited to the purchase price). Any amount paid to rent the equipment will be applied towards the purchase price; and

c. Benefits will be limited to standard models, as determined by the Plan; and

d. The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless Medically Necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan; and

e. If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repair or replacement due to abuse or misuse, as determined by the Plan Sponsor, is not covered.

Excluded are:

a. Home traction units.

b. Equipment used to provide exercise to functioning and non-functioning portions of the body when leased, purchased, or rented for use outside a recognized institutional facility.

c. Equipment designed to provide the walking capability for individuals with non-functioning legs.

13. Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**.

14. **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

15. Prophylactic **Mastectomy** or **Oophorectomy** (ovary removal surgery). Even though a current cancer diagnosis does not exist, risk-reducing surgery will be considered the same as any other Illness when there is an increased risk of breast or ovarian cancer, when a documented family history exists of breast or ovarian cancer, or when genetic testing demonstrates the existence of the cancer risk.

16. **Medical/Surgical Supplies.** Covered Charges for Medically Necessary Medical and Surgical Supplies. This includes gradient compression stockings and gradient compression wraps with a Physician's written order. These items may commonly be called anti-embolism, custom, circular knit, flat-knit, silver, or lymphedema compression stockings.

Excluded are:
Gradient Compression stockings or wraps used for athletic purposes, and
Support stockings, usually those with less than 18 mmHg, sold over the counter.

17. Treatment of **Mental Disorders and Substance Abuse**. These benefits may not be less than the benefits required under federal mental health and substance abuse parity requirements. All treatment is subject to the benefit payment shown in the Schedule of Benefits.

18. Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges if that care is for the following oral surgical procedures:

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

b. Emergency repair due to Injury to sound natural teeth. This includes replacement of natural teeth lost due to an Injury.

c. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

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

e. External incision and drainage of cellulitis.

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

g. Removal of impacted teeth.

h. X-rays related to above services.

i. General anesthesia for covered oral surgery.

j. Facility Charges determined to be Medically Necessary for dental care, and provided to the following persons:

1.) Covered Dependent Children five years of age or under; or
2.) A Covered Person who is severely disabled; or
3.) A Covered Person who has a medical or behavioral condition, which requires Hospitalization or general anesthesia when dental care is provided.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

19. Coverage of **Newborn Nursery/Physician Care**. Hospital and Physician nursery care for newborns who are eligible Dependents properly enrolled in the Plan as set forth below:

a. Hospital nursery care for a newborn during the Child's initial Hospital confinement at birth;
b. The following Physician services for well-baby care during the newborn's initial Hospital confinement at birth:
(i) The initial newborn examination and a second examination performed prior to discharge from the Hospital; and
(ii) Circumcision;

Covered Charges will be applied to the Plan of the Child, and the Child's own Deductible and Co-insurance provisions will apply.

If the newborn Child suffers an Illness or Sickness the care, treatment, services, and supplies necessary to treat the medical condition are considered the same as any other Illness or Sickness. The charges will be applied to the Plan of the Child, and the Child's own Deductible and Co-insurance provisions will apply.

In all cases, the Child must be properly enrolled in the Plan to obtain Plan benefits.

20. **Nutritional Supplements** which are Physician prescribed or other enteral supplementation necessary to sustain life including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation. Special dietary treatment for phenylketonuria (PKU) including over-the-counter nutritional supplements is a Covered Charge when prescribed by a Physician. Over-the-counter nutritional supplements or infant formulas – other than for treatment of PKU - will not be considered eligible even if prescribed by a Physician. Rental or purchase of equipment is subject to the Durable Medical Equipment benefit shown in the Schedule of Benefits. The supplements are subject to the Medical/Surgical Supplies as shown in the Schedule of Benefits.

21. Care, services and treatment of **obesity/Morbid Obesity** the same as any other Illness when Medically Necessary. Excluded are fees for club/gym memberships or membership fees of any kind or type; costs associated with enrolling/attendance in an exercise program; appetite suppressants, nutritional supplements or food products unless specifically stated elsewhere; and equipment used for exercise including - but not limited to - treadmills, elliptical machines, weight machines, pools or hot tubs of any type.

22. **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, Maintenance Therapy or supplies used in occupational therapy.

23. **Organ transplant limits**. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ, bone marrow or tissue transplant are subject to these limits:

a. The transplant must be performed to replace an organ, bone marrow or tissue.

b. The transplant must be a human-to-human organ, bone marrow, or tissue transplant.

c. All other conventional means of treatment have been unsuccessful in treating the condition.

d. The condition is covered by the Plan.

e. The Covered Person is obligated to pay for the transplant; it is not covered by a government agency or transplant program.

f. The transplant is not considered Experimental and/or Investigational.

g. The transplant must be performed at a Designated Transplant Facility. Cornea and skin grafts/transplants are excluded from this limit.

The following charges for obtaining donor organs, marrow or tissue are Covered Charges under the Plan: **(i)** evaluating the organ, marrow or tissue; **(ii)** removing the organ, marrow or tissue from the donor; and **(iii)** transportation of the organ, marrow or tissue from within the United States and Canada to the place where the transplant is to take place.

If the recipient is a Covered Person under this Plan but the donor is not, then this Plan will cover the donor's charges as those of the recipient. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan.

If both the donor and the recipient are Covered Persons under this Plan, eligible expenses incurred by each person will be treated separately for each person.

If the recipient is not a Covered Person under this Plan, then the donor's charges are not covered under this Plan.

The Designated Transplant Facility's contracted rate supersedes any negotiated PPO Network discount. Eligible transplant charges received at a Designated Transplant Facility are subject to Network benefits.

Excluded are lodging expenses including meals; expenses related to the Covered Person's transportation; the purchase price of any bone marrow, organ, tissue, or any similar items, which are sold rather than donated; and transplants which are not medically recognized and are Experimental and/or Investigational in nature.

24. The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. In all cases, repair or replacement due to abuse or misuse, as determined by the Plan Sponsor, is not covered.

Excluded are:

a. Benefits are not payable for special or extra-cost convenience features.

b. Foot only Orthotics except as described under "Diabetic Supplies, Equipment, and Self-Management Program".

c. Over the counter shoe inserts or orthotic devices.

25. **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

26. **Podiatry.** Treatment for the following foot conditions: **(i)** bunions, when an open cutting operation is performed; **(ii)** toenails, when at least part of the nail root is removed; **(iii)** any Medically Necessary surgical procedure required for a foot condition.

27. **Prescription Drugs** (as defined). The Plan provides coverage for Outpatient Prescription Drugs through the Prescription Drug Card program. Medications administered in the Physician's office or other Medical Care Facility are Covered Charges under the Medical Benefits subject to the exclusions and limitations of the Plan.

28. **Preventive Care Services.** Covered Charges under Medical Benefits are payable for Preventive Care Services as shown in the Schedule of Benefits. Additionally, the Employer-sponsored immunization clinic and/or preventive lab fair, if any, are Covered Charges under this Plan and reimbursed without cost-sharing regardless of the providers network or non-network affiliation.

Mammograms

Benefits for mammograms vary depending upon the reason the procedure is performed and the way in which the provider files the claim:

a. If the mammogram is performed in connection with the diagnosis or treatment of a medical condition and the provider properly files the claim with this information, the claim will be processed as a diagnostic procedure according to the benefit provisions of the Plan dealing with diagnostic x-rays.

b. If the Covered Person is at high risk of developing breast cancer or has a family history of breast cancer and the provider properly files the claim with this information, the claim will be processed as a preventive procedure according to the benefit provisions of the Plan's Preventive Care Services.

In all other cases the claim will be subject to the provisions described for Preventive Care Services.

Colorectal Cancer Screenings

Benefits for colorectal cancer screenings vary depending upon the reason the procedure is performed and the way in which the provider files the claim:

a. If the colorectal cancer screening is performed in connection with the diagnosis or treatment of a medical condition and the provider properly files the claim with this information, the claim will be processed as a diagnostic procedure according to the benefit provisions of the Plan dealing with surgical procedures. If a polyp is removed during the course of a preventive colonoscopy, the colonoscopy procedure, removal of the polyp, and the charges for pathological examination of the specimen are considered under the Plan's Preventive Care Services.

b. If the Covered Person has a family history of colon cancer and the provider

properly files the claim with this information, the claim will be processed as a preventive procedure according to the benefit provisions of the Plan's Preventive Care Services.

In all other cases the claim will be subject to the provisions described for Preventive Care Services.

The Plan intends to comply with the Affordable Care Act. Preventive Care Services may be added without notification. Contact the Claims Administrator if you have questions about these benefits.

29. The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts as shown in the Schedule of Benefits.

Replacement devices must be Medically Necessary due to growth, other physiological change, change in the Covered Person's condition, or deterioration of the device which renders repair unacceptable. Benefits are not payable for special or extra-cost convenience features. In all cases, repair or replacement due to abuse or misuse, as determined by the Plan Sponsor, is not covered. Dental plates, bridges, orthodontic braces, and dental prosthesis are excluded under this benefit and are not considered eligible expenses by the Plan.

Coverage is available for two (2) post-mastectomy bras per Covered Person per Benefit Year. A post-mastectomy bra is a bra that is specifically designed and intended to support single or bilateral breast prostheses.

The Plan covers Cochlear implants, auditory brainstem implants and osseiointegrated implants. Cochlear implants and auditory brainstem implants mean devices that replace the function of cochlear structures or auditory nerve and provide electrical energy to auditory nerve fibers and other neural tissue via implanted electrode arrays. Osseiointegrated implants mean devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer.

Benefits are also provided for penile prosthesis required for physiological (not psychological) impotence subject to advance approval by the Plan and only in the following situations: trauma, radical pelvic surgery, diabetes, Peyronie's Disease, vascular or neurological diseases when the individual situation warrants coverage in the Plan's opinion.

30. **Reconstructive Surgery.** Correction of a Congenital Abnormality, repair of damage from an accident or Illness, and reconstructive mammoplasties will be considered Covered Charges. This mammoplasty coverage will include reimbursement for:

a. reconstruction of the breast on which a mastectomy has been performed,
b. surgery and reconstruction of the other breast to produce a symmetrical appearance, and
c. coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas

in a manner determined in consultation with the attending Physician and the patient.

31. **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness.

32. **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. Physical medicine modalities including - but not limited to - correction or adjustment by manual; mechanical; electrical or physical means (including the use of light, heat, water or exercise) of structural imbalance; distortion; subluxation or misplaced tissue of any kind or nature of the human body. Coverage does not include nutritional supplements.

33. **Surgical Sterilization**. Reversal of sterilization is excluded.

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

35. A charge for **Telemedicine** services provided by a practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

36. Diagnostic **x-rays**.

PART III - COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Please refer to the Covered Person's ID card for the name of Cost Management Services and their phone number.

The provider, patient, family member or authorized representative must call this number to receive certification of certain Cost Management Services. This call must be made in advance of services being rendered or within three (3) business days after a Medical Emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Pre-certification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Hospitalization
Inpatient Substance Abuse or Mental Disorder treatments
Skilled Nursing Facility stays

After 48 observation hours, a confinement will be considered an Inpatient confinement. Observations in excess of 48 hours require pre-certification as an Inpatient stay. Pre-certification penalties may apply if observation exceeds 48 hours.

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

Pre-certification is the process of obtaining Medically Necessary certification. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Pre-certification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **in advance of the date** the services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee,
- The name, employee identification number and address of the covered Employee,
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, authorized representative, Medical Care Facility or attending Physician must contact the utilization review administrator **within three (3) business days** after the admission.

The utilization review administrator will determine the Medically Necessary number of days of Medical Care Facility confinement or use of other listed medical services. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive pre-certification for Inpatient admissions as explained in this section, the benefit payment will be reduced by 50% up to a maximum penalty of $750 per confinement.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days.

POST-SERVICE CLAIM REVIEW

The Plan reserves the right to conduct claim review to ensure that appropriate billing and coding guidelines are applied to Covered Charges. This includes - but is not limited to - guidelines as stipulated by the Centers for Medicare and Medicaid, the American Medical Association, and the Federal Register. Code edits including - but not limited to - reductions and/or denials based on the aforementioned guidelines may be applied.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if first and second opinions are contradictory) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if first and second opinions are contradictory) opinion will be paid as any other Sickness.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;
(2) related to the condition which causes the confinement; and
(3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable at the applicable Deductible and Co-Insurance even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;
-- contacting the family to offer assistance and support;
-- monitoring Hospital or Skilled Nursing Facility;
-- determining alternative care options; and
-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

PART IV - DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Affordable Care Act means the "Patient Protection and Affordable Act" enacted on March 23, 2010 and any amendments thereto.

Allowed Amount means the amount that the Plan determines to be the maximum amount payable for a service or supply provided. For services provided by Network Providers, the Allowed Amount is a negotiated amount that the Network Providers have agreed to accept as payment in full for services received by a Covered Person. For services received from providers who are not participating in the network, the Plan will either limit the amount it allows for Covered Charges to the lesser of (i) the provider's billed charge or (ii) an amount equal to 120% of the current Medicare allowable fee for the appropriate area, as such information is made publicly available. The Plan Administrator may, in its discretion, elect to issue an additional payment, in an amount not to exceed the Usual and Customary and Reasonable and Appropriate amount, if doing so is found to be in the best interest of the Covered Person. If there is no corresponding Medicare reimbursement rate for a charge from a non-network provider, the Allowed Amount will be an amount which is Usual and Customary, and Reasonable and Appropriate. The Covered Person is responsible for payment of Deductibles, Co-Payment/Co-Insurance amounts and non-covered services.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Approved Clinical Trial means a phase I, II, III or IV trial which is:

- **(1)** Conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, and
- **(2)** Is one of the following:
  - **(a)** Federally funded**,** or
  - **(b)** Is either:
    - **i** Conducted under an investigational new drug application (IND)reviewed by the Food and Drug Administration, or
    - **ii** A drug trial that is exempt from the IND application requirements.

Assisted Reproductive Technology (ART) means any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pronuclear stage tubal transfer, artificial insemination, intracytoplasmic sperm injection, embryo transport, selective reduction, and cryo-preservation.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Congenital Abnormality is a medical condition that existed at birth and is diagnosed within the first five years of life.

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person means an Eligible Individual and his/her Dependents who satisfy the eligibility conditions and has entered the Plan.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Deductible means the amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Benefit Year a Covered Person must meet the Deductible(s) shown in the Schedule of Benefits.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Designated Transplant Facility means a facility participating in a national transplant network, and the facility is available to deliver transplant services to a Covered Person based on a pre-arranged agreement with the Plan. A Designated Transplant Facility may or may not participate in the Plan's Preferred Provider Organization.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational means a drug, device, medical treatment or procedure that meets any of the following protocols:

(1) The drugs or dosages, devices, equipment, services, supplies, tests or medical treatment or procedures (generally, individually or collectively called ("Regimens")) have not received final approval from the U.S. Food and Drug Administration for the lawful marketing of the Regimens for the specific Injury or Illness to be treated.

(2) The Regimens have not received the approval or endorsement of the American Medical Association (AMA) for the specific Injury or Illness to be treated.

(3) The Regimens have not received the approval or endorsement of the National Institutes of Health (NIH) or its affiliated institutes for the specific Injury or Illness to be treated.

(4) The Regimens are to be or are being used or studied in proposed or ongoing clinical research or clinical trials as evidenced by an Informed Consent or treating facility's protocol; or are part of a proposed or ongoing Phase I, II, or III clinical trial; or are the subject of proposed or ongoing

research or studies to determine their dosage, safety, toxicity, efficacy, or their efficacy as compared to other means of treatment or diagnosis.

(5) The opinion of medical or scientific experts (as reflected in published reports or articles in medical and scientific literature; or the written protocol(s) used by the treating facility or other facilities studying substantially the same or similar drugs, devices, services, supplies, tests, treatments or procedures) indicates that further studies, research, or clinical trials of the Regimens are necessary to determine their dosage, safety, toxicity, efficacy, or their efficacy as compared to other means of treatment or diagnosis.

(6) The Regimens have not been proven effective for the specific Injury or Illness as of the date the treatment is provided.

Except,

(7) A drug shall not be considered Experimental and Investigational if all of the following criteria are satisfied:

(a) The drug is approved by the U.S. Food and Drug Administration regardless of the Injury, Illness or diagnosis; and

(b) The drug is appropriate and is generally accepted for the condition being treated by two of the following:

(i) American Hospital Formulary Service Drug Information;

(ii) National Comprehensive Cancer Network's (NCCN) Drugs & Biologics Compendium;

(iii) Thomson Micromedex DrugDex;

(iv) Elsevier Gold Standard Clinical Pharmacology.

Family Unit is the covered Participant and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third-party payor of safe, effective therapeutic drugs specifically covered by this Plan.

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

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; Medical Supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include Inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is a legally operated institution which meets at least one of these tests:

- **(1)** Is accredited as a Hospital under the Hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
- **(2)** Is a Hospital, as defined, by Medicare, which is qualified to participate and eligible to receive payments in accordance with the provisions of Medicare, or
- **(3)** Is supervised by a staff of Physicians, has twenty-four (24) hour-a-day nursing services, and is primarily engaged in providing either:
  - **(a)** General Inpatient medical care and treatment through medical, diagnostic and major surgical facilities on its premises or under its control, or
  - **(b)** Specialized Inpatient medical care and treatment through medical and diagnostic facilities (including x-ray and laboratory) on its premises, or under its control, or through a written agreement with a Hospital (which itself qualifies under this definition) or with a specialized provider of these facilities.
  - **(c)** A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health, if it meets all of the requirements set forth in clause (a) other than the major surgery requirement.
  - **(d)** A free-standing treatment facility, other than a Hospital, whose primary function is the treatment of Alcoholism or Substance Abuse provided the facility is duly licensed by the appropriate governmental authority to provide such service.

In no event will the term "Hospital" include a nursing home or an institution or part of one which:

- **(1)** Is primarily a facility for convalescence, nursing, rest, or the aged, or
- **(2)** Furnishes primarily domiciliary or custodial care, including training in daily living routines, or
- **(3)** Is operated primarily as a school.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means. It does not include disease or infection (unless it's pus-producing infection that occurred from an accidental cut or wound); hernia; or injuries caused by biting or chewing.

Inpatient means a Covered Person who receives care as a registered and assigned bed patient while confined in a Hospital, other than in its Outpatient department, Skilled Nursing Facility, Birthing Center or other Medical Care Facility where a room and board is charged by the facility which is properly licensed in the state for the services being rendered. Observation hours in excess of 48 hours will be considered an Inpatient admission.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure, or that are provided during periods when the medical condition of the patient is not changing, or does not require continued administration by medical personnel.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments, or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medical/Surgical Supplies means items for medical use other than drugs, Prosthetic or Orthotic Appliances, Durable Medical Equipment, or orthopedic footwear which have been ordered by a Physician in the treatment of a specific medical condition and which are usually:

(1) Consumable;
(2) Non-reusable;
(3) Disposable;
(4) For a specific rather than incidental purpose; and
(5) Generally have no salvageable value.

Medically Necessary means care and treatment is recommended or approved by a Physician (or Dentist, with regard to dental care); is consistent with the patient's condition or accepted standards of good medical (and dental practice) care; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical (and dental) services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Municipal Health Department means a local health department serving a municipality that meets the requirements of State public health laws and regulations.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Orthotic Appliance is an external device intended to correct any defect in form or function of the human body.

Outpatient is treatment including services, supplies and medicines provided and used at a Hospital, Medical Care Facility, or Birthing Center under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Prescription Savings Program means the program sponsored by the Employer which offers cost-saving opportunities on high-cost medications obtained through HCCI. Covered Persons can reduce their out-of-pocket expenses and costs to the Plan.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Prosthetic Device means a device which replaces all or part of a missing body organ and its adjoining tissue, or replaces all or part of the function of a permanently useless or malfunctioning organ. Prosthetic Devices do not include devices such as eyeglasses, hearing aids, orthopedic shoes, arch supports, Orthotic Devices, trusses, or examinations for their prescription or fitting.

Reasonable and Appropriate means an amount of Covered Charges that is identified as eligible for payment by the Plan Administrator in accordance with the terms of the Plan. These amounts may be determined and established by the Plan, at the Plan Administrator's discretion, using normative data such as, but not limited to, amounts the provider most often agrees to accept as payment in full either through direct negotiation or through a preferred provider organization network, average wholesale price, and/or manufacturer's retail pricing, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, rates negotiated with the Plan, and/or Medicare reimbursement rates. Medicare rates plus 20% are generally considered to be the Reasonable and Appropriate; however, the Plan Administrator may in its discretion, taking into consideration specific circumstances and negotiated terms, deem a greater amount to be payable. For purposes of defining "Reasonable and Appropriate," the terms(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, person or organizations rendering such treatment, services, or supplies for which a specific charge is made.

Reasonable and Appropriate claims shall be limited to those claims that, in the Plan Administrator's discretion, are services or supplies or fees for services or supplies that are necessary for the care and treatment of Illness or Injury not unreasonably caused by the treating provider. The determination whether fee(s) or services are Reasonable and Appropriate will be made by the Plan Administrator, taking into consideration such factors as,

but not limited to, the findings and assessments of the following entities: (a) national medical associations, societies, and organizations; and (b) the Food and Drug Administration. To be Reasonable and Appropriate, services(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable and Appropriate. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable and Appropriate based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable and Appropriate.

Reconstructive Surgery means surgery that is incidental to an Injury, Illness, or Congenital Abnormality when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such surgery as cosmetic when a physical impairment exists, and the surgery restores or improves function. The fact that a Covered Person may suffer psychological consequences, or socially avoidant behavior as a result of an Injury, Illness, or Congenital Abnormality does not classify surgery done to relieve such consequences or behavior as Reconstructive Surgery.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

Specialist means a Physician who concentrates on medical activities in a particular specialty of medicine, based on education and qualifications. A Specialist is not a General Medicine Practitioner, Internal Medicine Practitioner, Pediatrician, Family Practice Physician, Obstetrician, Gynecologist, Mental Health or Substance Abuse Practitioner.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Telemedicine means the mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telemedicine facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means that due to Sickness or Injury a Participant is not able to work at any job for pay or profit and is not able to engage in the normal activities of a person of like age and gender in good health; for a Child, Total Disability means the complete inability as a result of an Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Facility means a facility location, distinct from a Hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat Illness or Injury for unscheduled, ambulatory patients seeking immediate medical attention.

Usual and Customary ("U&C") means an amount of Covered Charges that is identified as eligible for payment by the Plan Administrator, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. For purposes of defining "Usual and Customary," the term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred. The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale. The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted), nor does it necessarily refer to the specific service or supply furnished to a Covered Person by a provider of services or supplies, such as a Physician, therapist, nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary. Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by using normative data such as, but not limited to, Medicare cost-to-charge ratios, average wholesale price for prescriptions. and/or manufacturer's retail pricing for supplies and devices.

Walk-in Retail Health Clinic/Convenience Care means a walk-in health clinic, other than an office, Urgent Care Facility, Pharmacy or independent clinic and not described by any other Place of Service code adopted by the Centers for Medicare and Medicaid Services that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.

PART V - PLAN EXCLUSIONS

Note: All exclusions related to the Prescription Drug Card are shown in the "Part VI - Prescription Drug Card Benefits" section. All exclusions related to dental benefits are shown in "Part VII – Dental Benefits".

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

A. **Abortion.** Expenses incurred for abortion. This exclusion does not apply when the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest or a fetal chromosomal abnormality exists which was diagnosed prior to the abortion. If complications arise after the performance of any abortion, expenses incurred to treat those complications will be eligible, whether the abortion was eligible or not.

B. **Adoptive birth mother.** Expense incurred by an adoptive birth mother.

C. **Alternative medicine,** including - but not limited to - biofeedback, aromatherapy, naturopathy, and homeopathic and holistic treatment or acupuncture/acupressure and hypnosis.

D. **Autopsies.**

E. **Chelation therapy**, except for acute arsenic, gold, mercury or lead poisoning.

F. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.

G. **Contraceptive Devices.**

H. **Counseling Services** and treatment related to relational problems, anti-social behavior, academic or phase-of-life problems, religious counseling, marital/relationship counseling, vocational or employment counseling and sex therapy.

I. **Court Ordered testing or rehabilitation.** Charges for court ordered testing or rehabilitation are not covered. Testing and rehabilitation are not covered if a Covered Person arranges in lieu of conviction, to undergo care or treatment as an alternative to, or in addition to, a fine or imprisonment.

J. **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

K. **Dental Care.** Care, treatment for dental services unless specifically stated.

L. Surgical treatment of scarring secondary to acne or chickenpox to include, but not to be limited to, **dermabrasion, chemical peel, salabrasion, and collagen injections**.

M. **Educational, recreational and vocational testing, training or therapy** services or any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies, except as may be required by applicable law. See "Covered Charges" for diabetic self-management.

N. **Evaluations and diagnostic tests** ordered or requested in connection with determinations of paternity, divorce, child custody, or child visitation proceedings.

O. **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowed Amount.

P. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

Q. **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

R. **External Defibrillators.** External Defibrillators which require the assistance of a third party for operation.

S. **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also excluded are lenses for the eyes and exams for their fitting. This exclusion for lenses does not apply to:

1. Aphakic patients,
2. Soft lenses or sclera shells intended for use as corneal bandages, and
3. Lenses for glasses following cataract surgery.

T. **Foot orthotics.** Foot orthotics including any casting or fitting charges, except as specifically stated under Covered Charges, "Diabetic Supplies, Equipment and Self-Management Programs".

U. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law. Also, this exclusion does not apply to Covered Charges rendered through the United States Veteran's Administration for non-service related Illness or Injury.

V. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

W. **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

X. **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Y. **Infertility.** Care, supplies and services for infertility except as stated.

Z. **Massage Therapy.** Charges for or related to massage therapy sessions.

AA. **Milieu therapy.** Milieu therapy or any confinement in an institution primarily to change or control one's environment.

BB. **Mouth, teeth and gum.** Care and treatment for mouth, teeth and gum whether considered medical or dental in nature except a specifically stated by the Plan.

CC. **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

DD. **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital, Medical Care Facility, or Skilled Nursing Facility against medical advice.

EE. No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay.

FF. No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

GG. Not specified as covered. Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan. These services include, but are not limited to, missed appointments, completion of claim forms, professional charges for travel expenses, mileage, traveling time, and independent expenses for telephone calls, faxes, and electronic communications. Excluded also are Physician's fees for any treatment, which is not rendered by a Physician.

HH. Occupational. Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

II. Personal comfort items. Personal comfort items or other equipment including - but not limited to - air conditioners, air-purification units, humidifiers, dehumidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, hot tubs, pools, hypo-allergenic pillows, power assist chairs, railings, ramps, waterbeds, non-prescription drugs and medicines, first-aid supplies, and non-hospital adjustable beds regardless of a Physician's written order, recommendation or reason the item is to be used.

JJ. Plan design excludes. Charges excluded by the Plan design as mentioned in this document.

KK. Radioactive contamination. Radioactive contamination or the hazardous properties of nuclear materials.

LL. Relative giving services. Professional services performed by a person who is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

MM. Replacement braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

NN. Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

OO. Sex change operation. Surgery for sexual reassignment or change.

PP. Sexual dysfunction. Charges for treatment of sexual dysfunction not related to organic disease.

QQ. Sleep disorders. Care and treatment for sleep disorders unless deemed Medically Necessary.

RR. Smoking cessation. Care and treatment for smoking cessation programs, including smoking deterrent products, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma. Tobacco deterrents are also covered under the Prescription Drug card.

SS. Training. Charges for orthoptics, vision training, vision therapy or subnormal vision aids.

TT. Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician. This exclusion does not apply to:

1. Ambulance charges as defined as a Covered Charge; or

2. Travel and/or lodging expenses covered by the Prescription Savings Program.

UU. War. Any loss that is due to a declared or undeclared act of war.

PART VI - PRESCRIPTION DRUG CARD BENEFITS

Pharmacy Drug Charge

Participating Pharmacies have contracted with the Pharmacy Benefit Manager to charge Covered Persons reduced amounts for covered Prescription Drugs under the Plan. Refer to the Covered Person's identification card for the name of the Pharmacy Benefit Manager, telephone number and website address.

If a drug is purchased from a non-participating Pharmacy, the amount payable in excess of the amounts shown in the Schedule of Benefits will be the ingredient cost and dispensing fee.

Co-Payments

The Co-Payment is applied to each covered Pharmacy drug charge and is shown in the Schedule of Benefits. The Co-Payment amount accumulates toward the Prescription Drug maximum out-of-pocket amount.

Covered Prescription Drugs

(1) All legend drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one legend drug ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection, except Growth Hormones.

(5) Vaccines. Limitations may apply by Pharmacy.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

The Plan Administrator reserves the right to review medications for coverage or exclusion by the Plan. Contact the Pharmacy Network listed on the Covered Person's identification card for more information about prescription drug coverage by the Plan.

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Biological sera.** Antigens, blood or blood plasma, parenterals and radiologicals.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

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

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(6) **Erectile Dysfunction drugs.** Drugs used to treat erectile dysfunction.

(7) **Experimental.** Experimental drugs and medicines as defined by the Plan, even though a charge is made to the Covered Person.

(8) **FDA.** Any drug not approved by the Food and Drug Administration.

(9) **Growth Hormones.** Charges for drugs to enhance physical growth or athletic performance of appearance.

(10) **Infertility.** A charge for infertility medication.

(11) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(12) **Investigational medications as defined by the Plan.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(13) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(14) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(15) **Outside the United States.** A charge for Prescription Drugs obtained outside the United States for consumption in the United States. This exclusion is not applicable to medications purchased through the Prescription Savings Program independent of MedTrak Pharmacy Services.

(16) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(17) **Other Exclusions.** Such other exclusions selected by the Plan Sponsor and applied by the Pharmacy Benefit Manager pursuant to the implementation documents of the Plan, which may be updated on an annual basis. For information related to specific exclusions, please contact the Pharmacy Benefit Manager.

Prior authorization is required for any Prescription Drug costing $1,250 or more per script.

PART VII - DENTAL BENEFITS

Dental Benefits apply when dental Covered Charges are incurred by a Covered Person. All benefits described in this Dental Benefits section are subject to the exclusions and limitations described more fully herein including - but not limited to – the Plan Administrator's or delegated party's determination that: care and treatment is Medically Necessary; charges are the Allowed Amount; services, supplies and care are not Experimental and/or Investigational. The meanings of certain capitalized terms are in the Core Documents "Definitions" section and the "Defined Terms" section of this Benefit Description.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Benefit Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Benefit Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Benefit Year, benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. Payment will be made at the percentages shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Amount Payable.

MAXIMUM BENEFIT AMOUNT

The Maximum Amount Payable for dental benefits is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Allowed Amount charged by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

In order for benefits to be payable, the person must be covered on the date the dental treatment is received. Most dental treatment is considered to have been received on the date the work is done. However, there are some kinds of treatment that take more time to complete. In these cases, treatment is considered to have been received on the dates shown below.

i. As to fixed bridgework, crowns, inlays, onlays and gold restorations, the date the tooth or teeth are first prepared.
ii. As to full or partial removable dentures, the date the impression is taken.
iii. As to root canal work, the date the pulp chamber is opened.
iv. As to an appliance or modification of an appliance, the date the impression is taken.

ORDER OF CLAIMS

If a service is covered by both the Medical and Dental Benefits, the Medical Benefits are considered first. The Allowed Amount for Dental Benefits is considered after the Medical Benefits.

COVERED DENTAL SERVICES

Class I Services: Preventive Dental Procedures

The limits on Class I Services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of two (2) exams per Covered Person each Benefit Year. Cutterage and scaling performed in conjunction with and on the same day as a routine exam will be considered part of the routine exam procedure.

(2) Dental imaging services required to treat or diagnose diseases or abnormalities of the teeth, surrounding tissue, and cavity detection, including those provided in association with a covered dental implant limited as follows:

- **(a)** Bitewing x-ray series limited to twice (2) per Benefit Year.
- **(b)** One full-mouth x-ray as part of a routine oral exam twice (2) per Benefit Year.
- **(c)** All other dental imaging services as deemed dentally appropriate.
- **(d)** If full-mouth and bite-wing x-rays are performed in conjunction with each other, the total amount payable will be based on the Usual and Reasonable Charge for a full-mouth x-ray.

(3) Fluoride treatment for covered Dependent children under age 19 twice (2) per Benefit Year.

(4) Sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age 19, once per tooth in any three Benefit Years.

(5) Problem focused exams.

Class II Services: Basic Dental Procedures

(1) Space maintainers for covered Dependent children to replace primary teeth.

(2) Emergency palliative treatment for pain.

(3) Periodontics (gum treatments).

(4) Endodontics (root canals).

(5) Extractions. This service includes local anesthesia and routine post-operative care.

(6) Re-cementing bridges, crowns or inlays.

(7) Fillings, other than gold.

(8) General and local anesthetics, upon demonstration of Medical Necessity.

(9) Antibiotic drugs which are injected by a Dentist.

Class III Services: Major Dental Procedures

(1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(2) Dental Implants.

(3) Installation of crowns, inlays and abutments.

(4) Installing precision attachments for removable dentures.

(5) Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during a six-month period following the installation.

(6) Addition of clasp or rest to existing partial removable dentures.

(7) Initial installation of fixed bridgework to replace one or more natural teeth.

(8) Repair of crowns, inlays, onlays, bridgework and removable dentures.

(9) Rebasing or relining of removable dentures over six-months old once every thirty-six (36) months. If the benefits pay for new dentures, it will not pay to rebase or reline the old dentures.

(10) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace extracted natural teeth. However, this item will apply only if one of these tests is met:

(a) The replacement or addition of teeth is required because of one or more natural teeth being extracted.
(b) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
(c) The existing denture is of an immediate temporary nature.

ALTERNATE TREATMENT

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

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

EXCLUSIONS

A charge for the following is not covered:

(1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

(2) **Broken appointments.** Charges for broken or missed dental appointments.

(3) **Cosmetic Dentistry.** Facings on crowns or pontics beyond the second bicuspid are considered cosmetic, except for Injuries or Medically Necessary care and treatment of cleft lip and palate.

(4) **Crowns for teeth that are restorable** by other means or for the purpose of Periodontal Splinting.

(5) **Excluded under Medical.** Services that are listed as excluded under Medical Benefits section of the Plan.

(6) **Home Sealant Kits.**

(7) **Hospital**, healthcare facility or medical emergency room charges.

(8) **Oral hygiene**, plaque control programs or dietary instructions.

(9) **Orthodontic Services.**

(10) **Orthognathic surgery**. Surgery to correct malpositions in the bones of the jaw.

(11) **Patient education** services.

(12) **Personalization of dentures.**

(13) **Recall visits** for checking sealant application.

(14) **Replacement of lost** or stolen appliances.

(15) **Services** which are **not included** in the list of covered dental services.

(16) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

(17) Charges for the treatment of Temporal Mandibular Joint dysfunction **(TMJ).**