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ABC COMPANY

EMPLOYEE BENEFIT PLAN

PLAN DOCUMENT
AND
SCHEDULE OF BENEFITS

PRECIS INTEGRATED HEALTH PLAN

Effective Date: Month Date, Year

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INTRODUCTION

Please read the Plan Document and Schedule of Benefits thoroughly and become familiar with the provisions of the Plan. This Plan Document and Schedule of Benefits describe the benefits available to you and your covered dependents under the [ABC Company] Employee Benefit Plan (the "Plan") administered by Hawaii Mainland Administrators, LLC (the "Claims Administrator") and describes the main features of the Plan, including:

- who is eligible for coverage;
- services that are covered;
- services that are not covered;
- what to do when you need care;
- how benefits are paid;
- when coverage ends; and
- your rights and responsibilities under the Plan:

There are terms in this document that have a special meaning under this Plan and are listed in the "Definitions" sections. When reading the provisions of the Plan, it may be helpful to refer to this section. Becoming familiar with the terms defined in this section will give you a better understanding of the procedures and benefits described.

In addition to this booklet describing your benefits, you will receive a member identification card that indicates you are eligible for coverage. This card contains your personal identification number, name, employer number and your employer plan name. The reverse of your card contains claims filing information. Always carry this card with you when you or your covered dependents visit the hospital, doctor or pharmacy. The card can be used to verify coverage, and contains information that must be on every claim form submitted for consideration of payment. The information on the reverse of the card is necessary for proper submission of claims and provides telephone numbers for inquiries. If you lose your card, contact your Claims Administrator to have the card reissued.

PURPOSE AND EFFECTIVE DATE

The purpose of the Plan Document and Schedule of Benefits is to set forth the provisions of the benefits plan (the "Plan") which provide for the payment of all or a portion of Covered Benefits the Plan Administrator agrees to pay, subject to all the provisions of the Plan, including amendments, on behalf of the Member entitled to such benefits while covered under this Plan, provided claim is duly made.

The Plan Document and Schedule of Benefits supersede all other documents and previously issued amendments and shall be the sole document used in determining benefits to which Members are eligible. The Plan may be amended from time to time by the Plan Administrator to reflect changes in benefits or eligibility requirements. Any amendments shall be binding on each Member covered and on any other individual or individuals referred to in this Plan Document. The benefits described in this document have been designed to pay a large portion of the Reasonable fees for a broad range of necessary medical services, treatments, and supplies and will give you substantial protection against the cost of serious sickness and injuries. This Plan is not in lieu of and does not affect any requirements for coverage by Workers' Compensation.

The Plan Administrator intends to continue the Plan indefinitely, but reserves the right to amend or terminate the Plan in whole or in part, at any time. Such action may include, but not be limited to the type of benefit, Deductible, Copayments, Coinsurance, Out-of-Pocket maximums, Maximum Payable Amount, limitations and exclusions, and monthly contribution. Any such action will be communicated to Members in writing as soon as reasonably possible but no later than 60 days prior to the effective change date.

PAYABLE AMOUNTS

This Plan offers a network provider option. The chosen Participating Provider Organization is comprised of a group of physicians and other health care providers from whom Members may obtain some of the covered medical services described within this document.

When you obtain Covered Benefits from a Participating Provider, this Plan offers the following advantages:

- You usually pay less money out of your pocket for health care services;
- You may change your provider at any time, because you are not required to designate a primary care physician;
- The Participating Provider will file claims directly to the Claims Administrator or the network, so you do not have to wait for reimbursement; and
- You only pay coinsurance, copayments or charges not covered by the Plan. You are not responsible for charges for Covered Benefits over the Plan's Maximum Allowable Amount.

This Plan utilizes a network for some providers but not others. All Hospital and other Facility charges, as well as Dialysis and Ambulance charges, are payable on a Reference-Based Pricing basis, as defined within this Plan. In-network Physician and ancillary care service charges are payable based on a negotiated rate when applicable. Out-of-network Physician and ancillary care service charges are payable strictly based upon Reasonable and Allowed..

The Plan's maximum payment will be limited to the Plan's Maximum Allowable Amount, as defined within this document.

When the Plan has a negotiated rate with certain Physicians, the Plan will pay benefits equal to that negotiated rate, as indicated in the Plan Exclusions section of this document. When the Plan does not have a negotiated rate, such as for Hospital and other Facility claims, as well as claims for Dialysis and Ambulance, the Plan's maximum payment is subject to the Reasonable and Allowed amount.

To determine whether a given claim will be paid based on a negotiated rate or Reasonable and Allowed, please refer to the Schedule of Benefits section of this document or contact the Claims Administrator.

All benefits payable under this Plan are also subject to the limits on specific benefits referenced within the Schedule of Benefits.

PLAN NOT A CONTRACT OF EMPLOYMENT

This Plan does not constitute a contract of employment or give any Member the right to be retained in the service of the Plan Administrator or to interfere with the right of the Plan Administrator to discharge or otherwise terminate the employment of any Member.

GENERAL INFORMATION

Name of Plan:	[ ]
Plan Number:	[ ]
Name, Address and Phone Number of Employer/Plan Sponsor:	[Name] [Address] [City, State, Zip Code] [(xxx) xxx-xxxx]
Employer Identification Number:	
Type of Plan:	[Precis Integrated Health Plan]
Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent For Service of Legal Process:	[Name] [Address] [City, State, Zip Code] [(xxx) xxx-xxxx] [ABC Company] shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan Documents and make all interpretive and factual determinations as to whether any individuals is entitled to receive any benefit under the terms of this Plan. Any construction of terms of any Plan Documents and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.
Source of Plan Contributions:	[ABC Company] and employees covered by the Plan contribute to the cost of the Plan**.** Employee contributions are the employee's share of costs as determined by the employer.
Funding Method:	The employer pays Plan benefits and administration expenses directly from general assets. Contributions received from Members are used to cover Plan costs and are expended immediately. Plan contributions are made by the employer and covered employee. All benefits under the Plan are paid from general assets. Employee required contributions are the employee's share of costs as determined by the employer. From time to time the employer will determine the required employee contributions and will notify employee in writing. Payments of Plan benefits will be based on the provisions of the Plan.
Initial Effective Date:	[Month Date, Year]
Benefits Plan Year:	[Month Date to Month Date]
Plan Renewal Date:	[Annually, Month Date]
Waiting Period:	[XX] days of continuous full-time employment.
Termination Date of Coverage:	[The last day of the month in which employment terminated or for which required premium was paid.]

Type of Administration of the Plan:	The self-funded Plan is administered directly by the Plan Administrator. The Plan Administrator has appointed a Claims Administrator to handle the day-to-day operation of the Plan. The Claims Administrator does not serve as an insurer, but only as a Claims Administrator. The Claims Administrator processes claims, then requests and receives funds from the Plan Administrator for the amount of the claims, and processes payment on the claims to hospitals and other providers.
Claims Administrator:	Hawaii Mainland Administrators, LLC (HMA) PO Box 22009 Tempe, AZ 85285-2009 (800) 448-3585
Right to Amend or Terminate the Plan:	The Plan Administrator reserves the right to amend or terminate this Plan at any time. You will be properly notified of any and all changes subject to the Plan's provisions.
Statement of ERISA rights:	The Plan Administrator holds the position that ERISA governs the Plan. The Employer is guided by ERISA provisions as applicable to its Plan. Accordingly, interpretations of the Plan, including words and phrases, shall be guided by ERISA as applicable to the Plan.

REQUIRED NOTICES

HIPAA PRIVACY STATEMENT-USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

The Plan Administrator agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
2. Ensure that any agents, including a subcontractor, to whom the Plan Administrator provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions unless authorized by a Member*;*
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Administrator unless authorized by the Member;
5. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to a Member in accordance with HIPAA's access requirements*;*
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an accounting of disclosures;
9. Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Health and Human Services Secretary for the purpose of determining the Plan's compliance with HIPAA; and
10. If feasible, return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

SEPARATION BETWEEN PLAN ADMINISTRATOR AND PLAN

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

1. Board of Directors
2. Administration
3. Human Resource/Financial Administration Support

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

WOMEN'S HEALTH & CANCER ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998(WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your claim administrator at (800) 448-3585.

NEWBORNS' ACT

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

MENTAL HEALTH PARITY

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, Deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits.

GENETIC INFORMATION NONDISCRIMINATION ACT

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information. GINA expands on the provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which protect against discrimination based on genetic information. HIPAA prevents a plan or issuer from imposing a preexisting condition exclusion based solely on genetic information, and prohibits discrimination in individual eligibility, benefits, or premiums based on any health factor (including genetic information).

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act (Affordable Care Act) adds many protections related to employment-based group health plans for you and your family. These include extending dependent coverage up to age 26; prohibiting preexisting condition exclusions for children under age 19 and for all individuals beginning in 2014; and requiring easy-to-understand summaries of a health plan's benefits and coverage.

Additional protections that may apply to your plan include the requirement to provide coverage for certain preventive services (such as blood pressure, diabetes and cholesterol tests, regular well-baby and well-child visits, routine vaccinations and many cancer screenings) without cost-sharing, and coverage of emergency services in an emergency department of a hospital outside your plan's network without prior approval from your health plan.

ERISA RIGHTS STATEMENT

As a Member in [ABC Company] Employee Benefit Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Members shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Securities Administration. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Plan Document and Summary of Benefits. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report.

The Plan Administrator is required by law to furnish each main subscriber with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Schedule of Benefits and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

SCHEDULE OF BENEFITS

The Schedule of Benefits is designed as a quick reference. For complete provisions of the Plan's benefits, refer to the following sections: Utilization Review, Medical Expense Benefit, Plan Exclusions and Participating Provider Organization (as well as Prescription Drug Program and Vision Expense Benefit). All Plan benefits are calculated from first day of [Month] through the last day of [Month]. Please refer to Schedule of Benefits herein enclosed.

Schedule of Benefits
Insert SOB

Insert SOB

Insert SOB

Insert SOB

Insert SOB

Insert SOB

Insert SOB

UTILIZATION REVIEW

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

Precertification establishes the medical necessity of certain care and services covered under the Plan. It ensures that the precertified care and services will not be denied on the basis of medical necessity (as defined by this Plan). The Precertification process will also establish the reference prices for requested services. However, precertification does not guarantee the payment of benefits. Coverage and benefits are always subject to other requirements and provisions of the Plan, such as, Plan limitations, exclusions, and eligibility at the time care and services are provided.

PRECERTIFICATION

Precertification Requirements are listed on the Schedule of Benefits indicating services that require precertification from the Claim Administrator Utilization Review Department in order for the services to be covered under the Plan.

All services requiring precertification, as noted on the Schedule of Benefits are to be certified in advance by the Utilization Review Department, except for emergencies. The Member or their representative is required to call the phone number for precertification located on the back of their ID card for the services specified above at least seven (7) business days prior to services being rendered. The Member or their representative must identify the services to be rendered and the associated diagnosis and procedure codes necessary for a precertification determination.

Emergency hospital admissions are to be reported to the Utilization Review Department within forty-eight (48) hours following admission, or on the next business day after admission.

When reviewing a precertification request, the Utilization Review Department will make sure the service is a Covered Benefit under your benefit plan. We also check the cost-effectiveness of the service and we may communicate with your doctor if necessary. If you agree, we may enroll you in one of our case management programs and have a nurse call to make sure you understand your upcoming procedure. It is your responsibility to make sure the service is precertified, so be sure to talk to your doctor about it. Failure to obtain precertification may result in additional costs to you beyond the Reasonable and Allowed amounts in addition to your Copayment, Deductible and Coinsurance amounts.

After admission to the hospital, the Utilization Review Department will continue to evaluate the Member's progress through concurrent telephonic review to monitor the length of confinement and medical necessity of treatment of any admission. If the Utilization Review Department disagrees with the length of confinement recommended by the physician, the Member and the physician will be advised. If the Utilization Review Department determines that continued confinement is no longer necessary, additional days will not be certified. Benefits payable for days not certified as medically necessary by the Utilization Review Department shall be denied. In the event certification of medical necessity is denied by the Utilization Review Department, the Member may appeal the decision. The Member may call the Utilization Review Department for more information concerning the appeal process. Additional information is listed in the Appeals Section of this document.

Precertification Penalty

The program requires the support and cooperation of each Member. If a Member follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Member fails to notify the Utilization Review Department of any service or treatment requiring precertification as indicated on the Schedule of Benefits, allowed charges will be reduced by 25%. The Member will be responsible for payment of the part of the charge that is not paid by the Plan in addition to any applicable Copayments, Coinsurance amounts and penalty amounts will not apply to Deductible and Out-of-Pocket Maximums.

TIMING OF NOTIFICATION

The Member shall be notified of the Plan's benefit determination on review as follows:

Urgent: If the physician classifies the precertification request as urgent, the Plan must recognize the request as urgent. Members must be notified of decisions as soon as possible, but no more than seventy- two (72) hours after receipt of the precertification request. (Urgent requests are based on the Member's condition and generally not for scheduling reasons.)

Routine: The Plan must make a benefit determination within fifteen (15) days after receipt of request from a Member, their representative or provider. This time period may be extended an additional fifteen (15) days if it is necessary because of matters beyond the Plan's control, and if the Plan notifies the Member of those circumstances and the expected date of the decision is before the end of the first fifteen (15) day period.

Concurrent: When a Member requests extension of an on-going course of treatment beyond that which the Plan has approved, the Plan must make a decision regarding the extension within one (1) business day after receipt of the request and notify the Member of the decision, provided the request for the extension was made at least one (1) business day before the end of the treatment which was already approved.

Retrospective: The Plan will make a benefit determination no later than thirty (30) days from the received date. If the retrospective review (a review completed after the event) determines that the hospitalization or surgery did not exceed the amount that would have been approved had the precertification been completed, there will be no penalty assessed and the amount of any deductable and/or Coinsurance will count towards the satisfaction of the Member's maximum Out-of-Pocket expense.

In the event that a precertification request is denied by the Utilization Review Department, the Member may appeal the decision. The Member may call the Utilization Review Department for more information concerning the appeal process. Additional information is listed in the Appeals Section of this document.

CASE MANAGEMENT/ALTERNATE TREATMENT

In cases where the Member's condition is expected to be or is of a serious nature, the employer may arrange for review and/or case management services from a professional qualified to perform such services. The employer shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of care.

The Utilization Review Department may recommend (or change) alternative methods of medical care or treatment, equipment or supplies that are not Covered Benefits under this Plan; or are Covered Benefits under this Plan but on a basis that differs from the alternative recommended by the Utilization Review Department. The Plan will recognize such alternative services as Covered Benefits. The use of case management or alternate treatment is a voluntary program to the Member; however, the Plan will generally provide a greater benefit to the Member by participating in the program.

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, , even if these expenses normally would not be eligible for payment under the Plan. In the event the Member and the attending Physician select a more expensive course of treatment, coverage under the Plan will be based upon the charge allowed for the alternate, less expensive, course of treatment.

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

REFERENCE-BASED PRICING (RBP)

Your benefit plan includes a Reference-Based Pricing (RBP) reimbursement model for certain types of providers and covered services.

Services subject to RBP include, but are not limited to Facilities, Dialysis, and Ambulance. Facilities will include services such as:

1. Any Inpatient services at a hospital, skilled nursing facility or behavioral health facility
2. Any Outpatient services at, or operated by a hospital, skilled nursing facility or mental/behavioral health facility including but not limited to:
    - A. Emergency room,
    - B. Laboratory services,
    - C. Radiology,
    - D. Pharmaceuticals,
    - E. Physical, Occupational, and Speech Therapies,
    - F. Respiratory Therapy/Pulmonary Therapy and
    - G. Other hospital, skilled nursing facility or behavioral health facility including
        - i. Hospital rehabilitation (physical therapy, for example),
        - ii. Hospital cardiac or pulmonary rehabilitation, and
    - H. Hospital Inpatient or Outpatient services
3. Any Outpatient or Ambulatory Surgery facility including endoscopy facilities
4. Any Outpatient CT, MRI, PET Scan, Lithotripter services

For services obtained under the RBP model the member may utilize any provider as there is no network. These providers will be reimbursed for covered and approved services based on RBP. RBP establishes a "Reasonable and Allowed" reimbursement amount for facilities based on Medicare and other published costs and pricing data applying either an additional amount on top of the Medicare amount or an additional amount on top of the facility costs (Medicare-plus or Cost-plus) for facility patient care.

RBP establishes the prevailing prices for medical services using objective and normative data such as Medicare Rates, cost data, average reimbursements/payments, Medicare Provider Reimbursement Manual et al, and other public and private data sources. The reference price takes into account prevailing area charges and other objective data to evaluate the reasonableness of the charges and validates the Medicare Allowable Prices specific to the services rendered.

The Plan Sponsors and Claims Administrators will work on your behalf to eliminate or minimize the potential for Member liabilities other than those due to Copayments, Coinsurance, Deductibles or amounts in excess of the RBP amounts. However, for services subject to RBP, the Member will be solely responsible for all amounts not paid by the Plan should the provider not accept the RBP amount as payment in full. The member has the right to request an estimated reimbursement prior to services being rendered including during the precertification process. Your Plan Sponsors and Claims Administrators intend to work with the providers prior to the services being rendered to ensure all parties have a better understanding of the RBP amounts as well as the providers' intentions to accept the RBP amounts.

LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable
for:

Excess Charges - Charges in excess of the Reasonable and Allowed charges for services or supplies provided.

NON REFERENCE-BASED PRICING

PARTICIPATING AND NON-PARTICIPATING PROVIDERS (ALL PHYSICIAN AND ANCILLARY SERVICES))

As indicated above, Facilities, Dialysis and Ambulance services are available to you without a Participating or Non-Participating designation and will have a single benefit level. For all covered and approved services other than those covered under the RBP section above. Members have the choice of using either a Participating Provider or a Non-Participating Provider. The Schedule of Benefits indicates covered services and what the benefit differential is between the use of Participating and Non-Participating Providers.

PARTICIPATING PROVIDERS

A Participating Provider is a physician ***or*** ancillary service provider which has an agreement in effect with the Participating Provider Organization (PPO) to accept a reduced rate for services rendered to Members. This is known as the negotiated rate. The Participating Provider cannot bill the Member for any amount in excess of the negotiated rate. Members may go to any provider of service. The Plan will determine if the provider is a Participating Provider and pay benefits at the negotiated rate. The Member is responsible for the difference between the percentage the Plan paid and one hundred percent (100%) of the negotiated rate for Participating Providers.

Advantages of using a Participating Provider:

1. The Member is not billed for charges that exceed the negotiated rate.
2. The Member saves money on health care costs because (a) of the reduced rate (negotiated rate) and (b) the Plan is able to provide greater benefits for the services of Participating Provider

How to use the Participating Provider

1. When the Member needs to see a physician or other health care provider, refer to the customer service and website information located on the back of the Members identification card. The Member should contact the provider to verify the provider is still a member of the Participating Provider Organization. If the provider is still a member, the appointment can be scheduled.
2. Upon arrival for the scheduled appointment, the Member should show the Participating Provider the identification card. The Participating Provider's billing office will submit the claim on behalf of the Member to the Claims Administrator.
3. If additional services from other providers are required, such as diagnostic x-ray and laboratory, the Member should ask the Participating Provider to ensure such other provider is also a Participating Provider.

NON-PARTICIPATING PROVIDERS

A Non-Participating Provider does not have an agreement in effect with the Participating Provider Organization. This Plan will allow only the Reasonable and Allowed amount as a Covered Benefit. The Plan will reimburse the Reasonable and Allowed amount based on Maximum Payable Amount for the Non-Participating Provider services, supplies and treatment. The Member is responsible for the remaining balance. This results in greater Out-of-Pocket expenses to the Member. For Non-Participating Providers, the Member is responsible for the difference between the percentage the Plan paid and one hundred percent (100%) of the billed amount.

REFERRALS

Referrals to a Non-Participating Provider are covered as Non-Participating Provider, supplies and treatments. It is the responsibility of the Member to assure services to be rendered are performed by Participating Providers in order to receive the Participating Provider level of benefits.

MEDICAL EXPENSE BENEFITS

This section describes the Covered Benefits of the Plan. All Covered Benefits are subject to applicable Plan provisions including, but not limited to, any applicable Deductible, Copayment or Coinsurance, as outlined within the Schedule of Benefits. All expenses incurred by the Member for services, supplies or treatment provided will not be considered Covered Benefits by this Plan if they are greater than the Maximum Payable Amount, as applicable. The Covered Benefits for services, supplies or treatment provided must be recommended by a physician or professional provider and be medically necessary care and treatment for the illness or injury suffered by the Member. Specified preventive care expenses will be covered by this Plan.

COPAYMENT

The Copayment is the amount payable by the Member for certain services, supplies or treatment. The service and applicable Copayment are shown on the Schedule of Benefits. The Member selects a provider and pays the provider the Copayment. The Plan pays the remaining Covered Benefits at the negotiated rate or Reasonable and Allowed amount. The Copayment must be paid each time a treatment or service is rendered. The Copayment will be applied toward the maximum Out-of-Pocket expense.

COINSURANCE

The Plan pays a specified percentage of Covered Benefits at the Reasonable and Allowed amount for Non-Participating Providers, or the percentage of the negotiated rate for Participating Providers. The percentage specified in the Schedule of Benefits is the percentage the Member is responsible for of the Reasonable and Allowed amount.

BENEFIT YEAR DEDUCTIBLE

Individual Benefit Year Deductible

The Deductible applies to all specific eligible charges during a benefit year for each covered person, as indicated in the Schedule of Benefits.

Family Benefit Year Deductible

Once the family has satisfied the maximum family Deductible, no further Deductible applies to any member of the family during the remaining benefit year. However, even if the employee and dependents are covered under the family coverage rules, no one individual is required to pay more than the individual benefit year Deductible.

BENEFIT YEAR OUT-OF-POCKET EXPENSE LIMIT

Individual Benefit Year Out-of-Pocket Expense Limit

After the Member has incurred an amount equal to the Out-of-Pocket expense limit listed on the Schedule of Benefits for Covered Benefits (after satisfaction of any applicable Deductibles), the Plan will begin to pay one hundred percent (100%) for Covered Benefits for the remainder of the benefit year.

Family Benefit Year Out-of-Pocket Expense Limit

After all family members have incurred a combined amount equal to the family Out-of-Pocket expense limit listed on the Schedule of Benefits; the Plan will pay one hundred percent (100%) of Covered Benefits for all covered family members for the remainder of the benefit year.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the benefit year Out-of-Pocket expense limit:

1. Expenses for services, supplies and treatments not covered by this Plan.
2. Charges in excess of the Maximum Payable Amount. 3. Penalties assessed for non-compliance with the precertification process.

MAXIMUM BENEFIT AMOUNTS

The Schedule of Benefits contains separate limitations called Maximum Benefit Amounts for specified conditions. Any separate Maximum Benefit Amount will include all such benefits paid by the Plan for the Member during any and all periods of coverage under this Plan. No more than the stated Maximum Benefit Amount will be paid for any Member while covered by this Plan.

COVERED MEDICAL EXPENSES

Some covered services require precertification as referenced in Utilization Review. Refer to the Schedule of Benefits for the services that require precertification.

ALTERNATIVE CARE SERVICES

ACUPUNCTURE

Acupuncture and/or electro-acupuncture to induce surgical anesthesia or for therapeutic purposes.

CHIROPRACTIC CARE

Covered Benefit includes initial consultation, x-rays and treatment.

NATUROPATHY

Naturopathy is a holistic approach to the diagnosis, treatment, and prevention of illness and injury. Covered Benefits include office visits/examinations. Covered Benefits do not include dispensed items, laboratory tests, or other diagnostic studies conducted by the naturopath.

MASSAGE THERAPY

Covered Benefits include the manipulation of soft tissue structures when performed by a licensed physician, chiropractor, or massage therapist.

AMBULANCE SERVICES

Ambulance services must be by a regularly scheduled airline, railroad, or by a licensed air or ground Ambulance.

Covered Benefits shall include:

1. Ambulance services for air or ground transportation for the Member from the place of injury or serious medical incident to the nearest hospital where treatment can be given.
2. Ambulance service is covered in a non-emergency situation only to transport the Member to or from a hospital or between hospitals for required treatment when such treatment is certified by the attending physician as medically necessary. Such transportation is covered only from the initial hospital to the nearest hospital qualified to render the special treatment.
3. Emergency services actually provided by an advance life support unit, even though the unit does not provide transportation.

APPLIANCES AND EQUIPMENT

DURABLE MEDICAL EQUIPMENT

Rental or purchase, whichever is less costly, of necessary durable medical equipment which is prescribed by a physician and required for therapeutic use by the Member shall be a Covered Benefit. The plan reserves the right to pay a monthly rental not to exceed the purchase price of the equipment. Equipment ordered prior to the Member's effective date of coverage is not covered, even if delivered after the effective date of coverage. Repair or replacement of purchased durable medical equipment which is medically necessary due to normal use or physiological change in the patient's condition will be considered a Covered Benefit. Maintenance contracts for purchased equipment will be considered a Covered Benefit.

Non-Preventive Service Breast Pumps are covered, but limited to the rental of a hospital-grade breast pump if an infant is unable to nurse directly on the breast due to a medical condition, such as prematurity, congenital anomaly and/or an infant is hospitalized.

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

PROSTHESES

Benefits for the initial provision and replacement of the following appliances and durable medical equipment:

1. hearing aids ((limited to one (1) device per ear every five (5) benefit years and a maximum of $1,500 per covered device);
2. cardiac pacemakers;
3. artificial limbs, eyes, and hips, and similar non-experimental appliances;

4. casts, splints, trusses, braces, and crutches;
5. external breast prostheses (limited to once every three (3) benefit years and the first permanent internal breast prosthesis necessary due to a mastectomy);
6. oxygen and rental of equipment for its administration;
7. rent or purchase of wheelchair and hospital-type bed (rental will be covered up to the purchase price); and
8. charges for use of an iron lung, artificial kidney machine, pulmonary resuscitator, and similar special medical equipment.

Equipment must be ordered by a Physician and approved by the Plan as medically necessary for the treatment of the illness or injury before the item will be considered a covered benefit. The purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a Covered Benefit. A prosthesis ordered prior to the Member's effective date of coverage is not covered, even if delivered after the effective date of coverage. Repair or replacement of a medically necessary prosthesis due to normal use or physiological change in the patient's condition will be considered a Covered Benefit.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a Covered Benefit. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered. Replacement will be covered only after five (5) years from the date of original placement, unless growth and development of a child necessitates earlier replacement.

Covered Benefits include therapeutic shoes or inserts for people with diabetes who have diabetic foot disease when prescribed by a podiatrist or other qualified doctor. A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes. Coverage is limited to one pair of therapeutic shoes or inserts per benefit year. Shoe modifications may be substituted for inserts.

SPECIAL EQUIPMENT AND SUPPLIES

Covered Benefits shall include medically necessary special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; ostomy supplies; catheters; syringes and needles for diabetes; other diabetic supplies, including insulin, test strips and blood sugar measurement devices; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract surgery; soft lenses or sclera shells intended for use in the treatment of illness or injury of the eye; support stockings, such as Jobst stockings, limited to two (2) pair per benefit year; surgical dressings and other medical supplies ordered by a professional provider in connection with medical treatment, but not common first aid supplies.

CLINICAL TRIALS

Benefits for an approved clinical trial, Prior Authorization is required

Criteria for approved clinical trials;

1. The clinical trial must be described in paragraph 1, 2 or 3 below.
   - A. **Federally funded trials**. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
     - i. *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*)
     - ii. *Centers for Disease Control and Prevention (CDC)*
     - iii. *Agency for Healthcare Research and Quality (AHRQ)*
     - *iv*. *Centers for Medicare and Medicaid Services (CMS)*
     - *v*. A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*
     - vi. A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
     - vii. The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
       - a) Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
       - b) Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

B. The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

2. Additional Requirements
A. The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
B. The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Qualified Individual

1. To be a qualified individual an individual must be
A. Covered under the health plan, and
B. Eligible to participate in an approved clinical trial according to the trial protocol based upon:
i. The individual was referred to the clinical trial by an in-network health care professional who has concluded that the individual's participation would be appropriate because the individual is eligible for the trial according to its protocol, **or**
ii. The individual provides the plan with medical and scientific information that establishes that participation would be appropriate because the individual is eligible for the trial according to its protocol.

Routine Patient Costs During Clinical Trials Include:

1. Covered Health Services for which Benefits are typically provided absent a clinical trial.
2. Covered Health Services required solely for:
A. The provision of the Investigational item or service (e.g. the infusion administration services to deliver an investigational drug), **and/or**
B. The clinically appropriate monitoring of the effects of the item or service (e.g. lab tests and imaging done at a frequency consistent with signs and symptoms and other standards of care for that diagnosis or treatment type), **and/or**
C. The prevention of complications.
3. Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service. **Network Plans:**
If one or more network providers are participating in a clinical trial, then the Plan Administrator may require that the Qualified Individual participate in the clinical trial using a network provider, as long as the network provider will accept the qualifying individual as a participant in the trial.

Note: Even though benefits may be available under this Contract for routine patient care related to an Approved Clinical Trial you may not be eligible for inclusion in these trials or there may not be any trials available to treat your Condition at the time you want to be included in a clinical trial.

BIRTHING CENTER

Covered Benefits shall include services, supplies and treatments rendered at a birthing center provided the physician in charge is acting within the scope of his license and the birthing center meets all legal requirements. Services of a midwife acting within the scope of his license or registration are a Covered Benefit provided that the state in which such service is performed has legally recognized midwife delivery.

CONTRACEPTIVE IUDS, CONTRACEPTIVE IMPLANTS, CONTRACEPTIVE INJECTABLES

Covered Benefits shall include:

Food and Drug Administration (FDA) approved contraceptive methods, when prescribed. Sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).

The methods covered by the pharmacy benefit are hormonal (e.g. birth control pills), barrier (i.e. diaphragms), emergency contraceptives (i.e. "morning after pill") and select over-the-counter (OTC) contraceptives, when prescribed by a health care provider. In addition, Covered Benefits shall include the supply of and administration of contraceptive IUDs, implants, and injectables when dispensed by a physician. Coverage for contraceptives is limited to one contraceptive method per period of effectiveness.

COSMETIC/RECONSTRUCTIVE SURGERY

Cosmetic surgery or reconstructive surgery shall be a Covered Benefit provided:

1. A Member receives an injury as a result of an accident and, as a result requires surgery. Cosmetic surgery or reconstructive surgery and treatment must be for the purpose of restoring the Member to his normal function immediately prior to the accident.
2. It is required to correct a congenital anomaly, for example, a birth defect.
3. It is for reconstructive breast surgery necessary because of a mastectomy. A breast reduction surgery for any other reason is not a Covered Benefit.
4. It is reconstructive breast reduction on the non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast.

DENTAL SERVICES

Covered Benefits shall include repair of sound natural teeth or surrounding tissue provided it is the result of an injury. Treatment must begin within ninety (90) days of the date of such injury and be completed within twelve (12) months after the injury. Damage to the teeth as a result of chewing or biting shall not be considered an injury under this benefit.

Covered Benefits shall also include charges for the surgical removal of bony or soft tissue impacted wisdom teeth or osseous surgery.

DIAGNOSTIC SERVICES AND SUPPLIES

Covered Benefits shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging and x-ray.

DIALYSIS

Covered Benefits include Dialysis Services, whether rendered in a Facility setting or in the home (hemodialysis or peritoneal Dialysis), diagnostic testing, laboratory tests, equipment and supplies provided by a Dialysis provider.

Dialysis Services, diagnostic testing, laboratory tests, equipment and supplies are a covered expense under the Plan only to the extent they are Medically Necessary, and only insofar as their cost does not exceed the maximum benefits specified on the Schedule of Benefits, specific to Dialysis Services.
Dialysis Services, diagnostic testing, lab expenses, equipment and supplies are those services and items used in the dialysis treatment for acute renal failure or chronic irreversible remain insufficiency (treatment of Anemia and other diagnoses related to renal failure). This also includes injectable and intravenous medication, including, but not limited to Heparin, Epogen, Procrit and other medications administered directly before, during or after a dialysis procedure. Dialysis procedures are for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis regardless of whether they are provided on an inpatient or outpatient basis

EMERGENCY SERVICES

Coverage is provided for health care services that are provided to a Covered Person in an Emergency. As defined in Federal legislation, the “prudent layperson” perception of what is an Emergency is used in determining Coverage under this Benefit. The use of emergency room services is only for injury or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health.
The Plan will not pay charges incurred for use of the Hospital's emergency room facilities, outpatient operating room, supplies, and equipment in connection with **non-emergency** surgical or medical services. If your condition requires immediate or urgent, but **non-emergency** care, contact your doctor or use an urgent care center.

The Plan will waive the Emergency Room Copayment if admitted as an Inpatient status.

ENTERAL NUTRITION THERAPY

Covered Benefits shall include enteral nutrition therapy for the treatment. Medicare classifies enteral nutrition therapy under the prosthetic device benefit. Coverage is only for therapy required due to the absence or malfunctioning body part which normally permits food to reach the digestive tract.

Enteral therapy may be given by nasogastric, jejunostomy, or gastrostomy tubes.

FAMILY PLANNING

Covered Benefits for infertility testing are limited to the actual testing for a cause of infertility. Any outside intervention procedures (e.g. artificial insemination) will not be considered a Covered Benefit.

HEARING AIDS

Charges for examination to determine hearing loss and the fitting, purchase, repair or replacement of a hearing aid.

HOME HEALTH CARE

Home health care enables the Member to receive treatment in his home for an illness or injury instead of being confined in a hospital or extended care facility. The "treatment period" shall mean each separate continuous home health care regimen as directed by the attending physician.

Covered Benefits shall include:

1. Part-time or intermittent nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse;
2. Physical, respiratory, occupational or speech therapy;
3. Part-time or intermittent home health aide services for a Member who is receiving covered nursing or therapy services;
4. Medical social service consultations;
5. Nutritional guidance by a registered dietician and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be medically necessary.

HOSPICE CARE

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

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

1. The Member is terminally ill, and
2. The Member has a life expectancy of six (6) months or less.

Covered Benefits shall include:

1. Confinement in a hospice to include ancillary charges and room and board.
2. Services, supplies and treatment provided by a hospice to a Member in a home setting.
3. Physician services and/or nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse.
4. Physical therapy, occupational therapy, or speech therapy.
5. Nutrition services to include nutritional advice by a registered dietician, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation.
6. Counseling services provided through the hospice.
7. Homemaker services.
8. Respite care by an aide who is employed by the hospice for four (4) hours per day. (Respite care provides care of the Member to allow temporary relief to family members or friends from the duties of caring for the Member.)
9. Bereavement counseling as a supportive service to Members in the terminally ill Member's immediate family. Benefits will be payable, provided:
    A. On the date immediately before death, the terminally ill person was covered under the Plan and receiving hospice care benefits; and
    B. Services are incurred by the Member within twelve (12) months of the terminally ill person's death and shall be limited to a maximum of twelve (12) visits.

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

HOSPITAL/AMBULATORY SURGICAL FACILITY

Covered Benefits shall include:

1. Room and board for treatment in a hospital, including intensive care units, cardiac care units and similar necessary accommodations. Covered Benefits for room and board shall be limited to the Reasonable and Allowed amount. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the Member.

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

3. Services, supplies and treatments described above furnished by an ambulatory surgical facility, including follow-up care provided within seventy-two (72) hours of a procedure.

4. Pre-Admission Testing

   Charges for pre-admission testing (x-rays and lab tests) performed within seven (7) days prior to a hospital admission which are related to the condition which is necessitating the confinement. Such tests shall be payable with no Deductible, at 100% of Reasonable and Allowed Reasonable amounts, even if they result in additional medical treatment prior to confinement or if they show that hospital confinement is not necessary. Such tests shall not be payable if the same tests are performed again after the Member has been admitted. This extent of coverage is contingent on the following conditions are met:
   A. The tests are related to the performance of the scheduled surgery or treatment;
   B. The tests have been ordered by a Physician after a condition requiring surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital;
   C. The Member is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary; and
   D. The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

5. Second Surgical Opinion

   If a Physician recommends surgery for a Member, the Member may request a second opinion as to whether or not the surgery is Medically Necessary.

   In addition, the Plan recommends that a second opinion be obtained prior to the following Surgeries:
   A. Adenoidectomy;
   B. Bunionectomy;
   C. Cataract removal;
   D. Coronary Bypass;
   E. Cholecystectomy (removal of gallbladder);
   F. Dilation and curettage;
   G. Hammer Toe repair;
   H. Hemorrhoidectomy;
   I. Herniography;
   J. Hysterectomy;
   K. Laminectomy (removal of spinal disc);
   L. Mastectomy;
   M. Meniscectomy (removal of knee cartilage, including arthroscopic approach);
   N. Nasal surgery (repair of deviated nasal septum, bone or cartilage);
   O. Prostatectomy (removal of all or part of prostate);
   P. Release for entrapment of medial nerve (Carpal Tunnel Syndrome);
   Q. Tonsillectomy; and
   R. Varicose veins (tying off and stripping).

When a second opinion is requested, the Plan will pay 100% of Reasonable and Allowed amounts incurred for that opinion along with laboratory, x ray and other Medically Necessary services ordered by the second Physician without application of the Deductible. Second opinions for Cosmetic Surgery, normal obstetrical delivery and surgeries that require only local anesthesia are not covered. If the second opinion does not concur with the first, the

Plan will pay for a third opinion as outlined above. The second or third opinion must be given within 90 days of the first.

HUMAN GROWTH HORMONE/GENETIC TESTING/COUNSELING

Covered Benefits for human growth hormone include replacement therapy services to treat:

1. Hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection, or radiation therapy.
2. Turner's syndrome.
3. Growth failure secondary to chronic renal insufficiency awaiting renal transplant.
4. AIDS-wasting or cachexia without evidence of suspected or overt malignancy and where other modes of nutritional supplements (e.g. hyperalimentation, enteral therapy) have been tried.
5. Neonatal hypoglycemia secondary to growth hormone deficiency.
6. Prader-Willi Syndrome.
7. Severe growth hormone deficiency in adults.
8. Replacement therapy services to treat short stature.

Covered Benefits include genetic testing and counseling, including but not limited to screenings recommended by the United States Preventive Services Task Force (USPSTF).

MASTECTOMY

Covered Benefits shall include the following:

1. Medically necessary mastectomy, including complications from a mastectomy, including lymphedemas.
2. Reconstructive breast surgery necessary because of a mastectomy.
3. Reconstructive breast surgery on the non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast.

MENTAL HEALTH/BEHAVIORAL HEALTH /SUBSTANCE ABUSE DISORDER

Inpatient or Partial Confinement

Covered Benefits shall include confinement in a hospital or treatment center for services, supplies and treatment related to the treatment of mental health disorders, eating disorders, substance abuse, chemical dependency, alcoholism or drug addiction. Two (2) days of partial confinement will be considered as one (1) day of inpatient confinement.

Covered Benefits shall include:

1. Inpatient hospital confinement;
2. Individual psychotherapy;
3. Group psychotherapy;
4. Psychological testing;
5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional provider.

Outpatient

Covered Benefits shall include outpatient services, supplies and treatment related to the treatment of mental health disorders, eating disorders, substance abuse, chemical dependency, alcoholism or drug addiction. Covered Benefits also include psychological testing.

PHYSICIAN SERVICES

Covered Benefits shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, inpatient visits, home visits.
2. Surgical treatment. Separate payment will not be made for inpatient pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.
   For related operations or procedures performed through the same incision or in the same operative field,
3. When two (2) or more unrelated operations or procedures are performed at the same operative session, Covered Benefits shall include the surgical allowance for each procedure.Surgical assistance provided by a physician if it is determined that the condition of the Member or the type of surgical procedure requires such assistance.

4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.
5. Consultations requested by the attending physician during a hospital confinement. The Plan will pay for one (1) such consultation per illness or injury. Consultations do not include staff consultations which are required by a hospital's rules and regulations.
6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.
7. Radiologist or pathologist services for diagnosis or treatment.
8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.
9. Services received in an urgent care or walk-in facility.

PODIATRY SERVICES

Covered Benefits shall include diagnosis, treatment and prevention of conditions of the feet, including surgical services, incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures of dislocations of bones of the foot.

PREGNANCY

Covered Benefits for pregnancy or complications of pregnancy shall be provided for a covered female employee, a covered female spouse of a covered employee, and dependent children.

The Plan shall cover services, supplies and treatments for medically necessary abortions when the life of the mother would be endangered by continuation of the pregnancy or when the fetus has a known condition incompatible with life.

Medical services incurred by the newborn of a dependent covered under this plan shall not be considered Covered Benefits. Complications from an abortion shall be a Covered Benefit whether or not the abortion is a Covered Benefit.

PRESCRIPTION DRUGS

The Plan shall cover prescription drugs that are approved for general use by the Food and Drug Administration and must be dispensed by a licensed pharmacist, physician or dentist.

PREVENTIVE CARE

The Plan shall provide coverage for evidence-based items or services, such as:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF);
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention;
3. Infants, children, and adolescents: Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
4. Women: additional preventive care and screenings not described above in number one (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
5. Current recommendations of the United States Preventive Service Task Force (USPSTF) regarding breast cancer screening, mammography, and prevention.

Preventive Screenings Include but are not limited to:

1. Abdominal aortic aneurysm by ultrasonography in men aged sixty-five (65) to seventy-five (75) who have ever smoked;
2. Mammograms with or without clinical breast examination as follows: one (1) baseline mammograms for women age thirty-five (35) through thirty-nine (39) and one(1) mammogram every benefit year for women age forty (40) and over;
3. Cervical cancer screening; cholesterol abnormalities;
4. Colorectal cancer beginning at age fifty (50) and continuing until age seventy-five (75);
5. Diabetes;
6. Depression;
7. Screening for hearing loss in newborn infants;
8. Osteoporosis;
9. Screening for visual acuity in children younger than age five (5).

Immunizations: Preventive immunizations from birth for all Members.

Pediatric: All preventive Pediatric Health Care services as recommended by the Bright Futures project.

Covered Benefits for Preventive Care services under this Plan also includes services such as:

1. Physical check-up;
2. One (1) gynecological examination and Papanicolaou test (Pap Smear) per benefit year;
3. Prostate examination and PSA test;
4. Routine colonoscopy;
5. Related diagnostic x-ray and laboratory.

REHABILITATIVE PROGRAMS

Covered Benefits shall include charges for qualified cardiac/pulmonary rehabilitation programs.

REHABILITATIVE SERVICES

Therapy services must be ordered by a physician to aid restoration of normal function lost due to illness or injury. Covered Benefits shall include services of a professional provider for physical therapy, occupational therapy, speech therapy or respiratory therapy. Covered Benefits do not include charges for recreational programs.

- **Physical Therapy** – physical therapy services are covered when ordered by a physician to aid restoration of normal function lost due to illness or injury, where significant improvement is expected within a predictable period of time. Prior Authorization is required and benefit limitations apply.
- **Occupational Therapy** – occupational therapy is covered when it is prescribed by a physician to relearn or to improve the level of independence in performing activities of daily living;(e.g., eating, bathing, dressing) or to provide task-oriented therapeutic activities designed to improve or restore physical functions lost or impaired as a result of illness or injury where significant improvement is expected within a predictable period of time. Prior Authorization is required and benefit limitations apply.
- **Speech Therapy** – speech therapy is covered when it has been ordered by a physician to restore or improve speech in Covered Person's who have speech/language disorders that are the result of an illness or injury where significant improvement is expected within a predictable period of time. Prior Authorization is required and benefit limitations apply.

Inpatient

Inpatient rehabilitative services are subject to precertification. Inpatient rehabilitative services shall also include room and board, including regular daily services and supplies furnished by the facility, physician and professional providers.

Outpatient

Outpatient rehabilitative services shall also include daily services and supplies furnished by the facility, physician and professional providers.

SKILLED CARE FACILITY

Skilled Care facility services, supplies and treatments shall be a Covered Benefit provided if:

1. The Member was first confined in a hospital for at least three (3) consecutive days or is in lieu of inpatient hospitalization;
2. The attending physician recommends extended care confinement for a convalescence from a condition which caused that hospital confinement, or a related condition;
3. The Skilled Care confinement begins within fourteen (14) days after discharge from a hospital confinement, or within fourteen (14) days after a related extended care confinement; and
4. The Member is under a physician's continuous care and the physician certifies that the Member must have twenty-four (24) hours-per-day nursing care.

Covered Benefits shall include:

1. Room and board (including regular daily services, supplies and treatments furnished by the Skilled Care facility) limited to the facility's average semiprivate room rate; and
2. Other services, supplies and treatment ordered by a physician and furnished by the Skilled Care facility for inpatient medical care.

STERILIZATION

Covered Benefits shall include elective sterilization procedures for the covered employee or covered spouse. Reversal of sterilization is not a Covered Benefit.

THERAPY SERVICES- CHEMOTHERAPY/RADIATION THERAPY/ IV INFUSION

Covered Benefits shall include facility charges and services of a professional provider for; chemotherapy; and IV infusion therapy whether rendered on an inpatient or outpatient basis.

TRANSPLANTS

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

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

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

3. Expenses incurred by the donor who is not ordinarily covered under this Plan according to Eligibility requirements will be Covered Benefits to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this Plan.

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

5. Transportation, lodging and meals for the covered recipient and one (1) other person (two (2) if the recipient is an eligible dependent child) to accompany the recipient to and from a facility for the actual transplant procedure if the covered transplant is performed in a facility authorized by the plan and the facility is more than 100 miles from the transplant recipient's residence. Any travel prior to the actual transplant procedure is not included in the benefit. Lodging and meals at or near the facility for the person(s) accompanying the recipient while confined are also a Covered Benefit up to the Maximum Payable Amount up to a maximum of $100 per day. There is a combined overall maximum benefit of $5,000 for any one transplant or procedure type for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures. Contact the Claims Administrator for instructions to obtain reimbursement.

6. Transplant services, including surgery, require prior authorization. Transplant services without prior authorization will not be covered. Any Member in need of an organ transplant may contact the Claims Administrator to initiate the pre certification process resulting in a referral to a Center of Excellence. The Claims Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admission taking place at a Center of Excellence.

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

   Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:

   A. Bone marrow;
   B. Heart;
   C. Lung;
   D. Heart and lung;
   E. Liver;
   F. Pancreas;
   G. Kidney; and
   H. Cornea.

   In addition, the Plan will cover any other organ transplant that is not Experimental, Investigational, or Unproven.

   Covered Benefits will be considered the same as any other Sickness for Members as a recipient of an organ or tissue transplant. Covered Benefits include:

   A. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
   B. Services and supplies furnished by a Provider; and

C. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

Surgical, storage and transportation costs (including donor medical expenses,) directly related to the procurement of an organ or tissue used in a transplant described herein will be covered at an amount not to exceed the actual cost of acquisition for each such procedure completed plus 15%. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.>

WELL NEWBORN CARE

The Plan shall cover well newborn care as part of the mother's claim while the mother is confined for delivery not to exceed forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean delivery. Such care shall include, but is not limited to:

1. Physician services
2. Hospital services
3. Circumcision

MEDICAL EXCLUSIONS

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

1. Charges for services, supplies or treatment for the reversal of sterilization procedures.
2. Charges for services, supplies or treatment related to the treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation, in vitro fertilization procedures and services, or Gamete Intrafallopian Transfer (GIFT).
3. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
4. Charges for treatment or surgery for sexual dysfunction.
5. Charges for hospital admission on Friday, Saturday or Sunday unless the admission is an emergency situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, hospital expenses will be payable commencing on the date of actual surgery.
6. Charges for inpatient room and board in connection with a hospital confinement primarily for diagnostic tests, unless it is determined by the Plan that inpatient care is medically necessary.
7. Charges for services, supplies or treatment for attention deficit disorders, behavior or conduct disorders, development delay, hyperactivity, learning disorders, mental retardation, autistic disease, or senile deterioration. However, the initial examination, office visit and diagnostic testing to determine the illness shall be a Covered Benefit.
8. Charges for biofeedback therapy.
9. Charges for services, supplies or treatments which are primarily educational in nature; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.
10. Charges for services, supplies or treatments provided by your Employer.
11. Charges for services, supplies or treatments provided by an educational institution as required by law.
12. Except as specifically stated in Medical Expense Benefit, Dental Services, charges for or in connection with: treatment of injury or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.
13. Charges for routine vision examinations and eye refractions; orthoptics; eyeglasses or contact lenses, except as specifically stated under Medical Expense Benefit, Special Equipment and Supplies; dispensing optician's services.
14. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.
15. Except as medically necessary for the treatment of metabolic or peripheral-vascular illness, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.
16. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a physician, such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment or other items considered “luxury medical equipment”, such as, motorized wheelchairs or other vehicles, bionic or computerized artificial limbs.
17. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.
18. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost are included in the orthotists charge) or shoe inserts.

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

20. Charges incurred as a result of, or in connection with, cosmetic surgery or any procedure or treatment excluded by this Plan which has resulted in medical complications.

21. Charges for services provided to a Member for an elective abortion. However, complications from such procedure shall be a Covered Benefit.

22. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutrisystem, Weight Watchers or similar programs; and hospital confinements for weight reduction programs.

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

24. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches; except as mandated under PPACA, Preventive Care.

25. Charges for employment physical, premarital lab work or any related charges and other care not associated with treatment or diagnosis of an illness or injury, except as specified herein.

26. Charges for custodial care, domiciliary care or rest cures.

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

28. Charges for wigs, artificial hair pieces, artificial hair transplants, or any drug - prescription or otherwise -used to eliminate baldness. This exclusion does not apply when baldness is the result of burns, chemotherapy, radiation therapy, or surgery. Under these conditions, purchase of a wig or artificial hair piece is limited to one (1) while covered by this Plan.

29. Charges for expenses related to hypnosis.

30. Charges for prescription drugs that are covered under the Prescription Drug Program.

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

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

33. Charges for room and board in a facility for days on which the Member is permitted to leave (a weekend pass, for example.)

34. Charges for reconstructive surgery for breast reduction, unless it is for reconstructive breast reduction following mastectomy on the non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast.

35. Charges for surgical and nonsurgical treatment of temporomandibular joint (TMJ), myofacial pain syndrome or orthognathic treatment, whether treatment is provided by a hospital, physician, dentist, physical therapist or oral surgeon. Charges for orthodontia or prosthetic devices prescribed by a physician or dentist.

36. Charges for a power wheelchair or scooter that is only needed and used outside of the home.

37. Amounts in excess of the Reasonable and Allowed with respect to Facility, Dialysis, and Ambulance claims, and out-of-network claims.

38. Marriage, relationship or financial counseling or sex therapy.

39. Speech therapy, rehab therapy, to only include restorative not developmental or maintenance care.

40. Robotic surgery must be pre-certified and subject to the plan's pre-certification penalty, if not pre-certified. Also, the surgery for which Robotic surgery is used shall not be greater than reimbursement of the amount covered when performed without Robotic surgery.

41. Any charges incurred by a dependent child of a covered dependent child are not Covered Benefits under this plan.

42. Non Approved Clinical Trials; Phase I, Phase II or Phase III clinical trial, being conducted in relation to the detection or treatment of non-life threatening cardiovascular disease (cardiac/stroke), surgical musculoskeletal disorders of the spine, hip and knees, and/or other clinical trials.
43. Approved Clinical Trials;
    A. Laboratory tests and imaging studies done at a frequency dictated by the study protocol and not consistent with signs and symptoms and other standards of care for that diagnosis or treatment type.
    B. Items and services provided by the research sponsors free of charge for any person enrolled in the trial
    C. Travel and transportation expenses are excluded from coverage. These include, but are not limited to, the following examples:
        i. Fees for all types of transportation. Examples include, but are not limited to: personal vehicle, taxi, medical van, ambulance, commercial airline, and train.
        ii. Rental car expenses.
        iii. Mileage reimbursement for driving a personal vehicle.
        iv. Lodging.
        v. Meals.
    D. Routine patient costs obtained out-of-network where non-network benefits do not exist under the plan.
    E. The investigational item, device or service itself
    F. Services inconsistent with widely accepted and established standards of care for a particular diagnosis
    G. Services related to an approved clinical trial received outside of the United States.

PLAN EXCLUSIONS

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

With respect to any services which are otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury or Illness if the Injury or Illness is the result of a documented medical condition or from the Member's being the victim of an act of domestic violence.

1. Charges for services, supplies or treatment from any hospital owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.
2. Charges for an injury sustained or illness contracted while on active duty in military service, unless payment is legally required.
3. Charges for services, supplies or treatment for treatment of illness or injury which is caused by or attributed to by war or any act of war (whether declared or undeclared, civil or international, or any substantial armed conflict between organized forces of a military nature), participation in a riot, civil disobedience or insurrection.
4. Charges in connection with any illness or injury arising out of or in the course of any employment intended for wage or profit, including self-employment.
5. Charges made for a service, supply and treatment which is not Medically Necessary for the treatment of illness or injury, or which are not recommended and approved by the attending physician, except as specifically stated herein.
6. Charges in connection with any illness or injury sustained while taking part or attempting to take part in an illegal act, including but not limited to misdemeanors and felonies; or for any Injury or Illness that arises from or is caused during the commission of any illegal act. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result for the Plan Administrator to determine that an act constitutes an illegal act. Proof beyond a reasonable doubt is not required to be deemed an illegal act. The Plan Administrator has the sole discretion to determine whether a particular act constitutes an Illegal Act.
7. Charges in connection with any activity made illegal due to the use of alcohol, controlled substances or chemicals, or charges in connection with any Injury or Illness sustained during, or as a result of, the use of alcohol. Expenses will be covered for Members other than the person partaking in the activity or a state of intoxication, and expenses may be covered for substance abuse treatment as specified elsewhere in this Plan, if applicable, and subject to all Plan limitations.
8. Any charge in connection with any Illness or Injury that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Plan Member's customary occupation or if it involves leisure time activities considered by the Plan Administrator, taking all circumstances into account, as involving unusual or exceptional risks, characterized by a threat of danger or risk of bodily harm. Hazardous pursuits, hobbies, or activities include, but are not limited to, reckless operation of machinery, travel to countries with advisory warnings, and use of weapons and explosives.
9. To the extent that payment under this Plan is prohibited by any law of the jurisdiction in which the Member resides at the time the expense is incurred.
10. Charges for services rendered and/or supplies received prior to the effective date or after the termination date of a Member's coverage.
11. Any services, supplies or treatment for which the Member is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
12. Charges for services, supplies or treatment that is considered Experimental/Investigational. The Plan Administrator has the sole discretion to make this determination.

13. Charges incurred outside the United States if the Member traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

14. Charges for services, supplies or treatment rendered by any individual who is a close relative, as determined by the Plan Administrator, of the Member or who resides in the same household as the Member.

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

16. Charges for illnesses or injuries sustained by a Member due to the action or inaction of any party if the Member fails to provide any information as specified in Subrogation section or as requested by the Plan in connection with any third-party recovery.

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

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

19. Benefits which are payable under any one section of this Plan shall not be payable as a benefit under any other section of this Plan. For example, if a benefit is eligible under both the Medical Expense Benefits section and the Prescription Drug Program section, and is paid under the Medical Expense Benefit, the remaining balance will not be paid under the Prescription Drug Program Benefit.

20. Charges for treatment of any intentionally self-inflicted illness or injury, including suicide or attempted suicide.

21. Excess Charges - Except as specifically stated otherwise, no benefits will be payable for: Charges in excess of the Reasonable and Allowed charges for services or supplies provided.

22. Court ordered treatment or services - charges for services, treatment or care of any kind that are provided due to a court order, or are required by a court of law and/or are imposed as an alternative to, or in addition to, fine or imprisonment. This exclusion shall not apply to expenses for the illness or injury that would be covered under the Plan in the absence of a court order, and for which the covered person is legally obligated to pay.

23. Private duty or shift care services of a health care provider

24. Examinations - charges for examinations, testing, vaccinations or other services related to employment, licensing, insurance, adoption, marriage license, sports, or camp applications, or travel outside the United States.

25. Taxes, Excise and Sales - You are not covered for tax of any kind imposed on medical services or Prescription Drug(s).

26. Administrative or Adjunctive Charges - charges for administrative fees; completion, filing or copying of claim forms, itemized bills or medical reports; reports or appearances in legal proceedings, mailing, postage, or shipping and handling; missed appointments; late fees; sales tax; interest or penalties; travel time or expenses; or telephone consultations.

27. Charges for the release and review of medical records

28. Duplicate Item - You are not covered for duplicate durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances that is intended to be used as a backup device, for multiple residences, or for traveling, e.g., a second wheeled mobility device specifically for work or school use or a backup manual wheelchair when a power wheelchair is the primary means of mobility. Note: ventilators at home are not included in this exemption).

29. A dependent child of a covered dependent child shall not be covered by this plan.

PRESCRIPTION DRUG PROGRAM

There are three (3) aspects of the Prescription Drug Program.

RETAIL OPTION

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

The Copayment is applied to each covered pharmacy drug charge and is shown on the Schedule of Benefits. The Copayment amount is not a Covered Benefit under the Medical Expense Benefit. Any one prescription is limited to a thirty-one (31) day supply or ninety (90) day supply for maintenance medication.

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

Dispense As Written (DAW) Penalty
If you or your doctor requests a brand-name medicine when a generic alternative is available, your prescription cost will be higher.
The Dispense As Written (DAW) Penalty is the amount you pay for a brand name drug when a generic drug is available. In these instances, you will pay the difference between the brand name drug and the generic drug.

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Members significant savings on prescriptions.

The Copayment is applied to each covered mail order prescription charge and is shown on the Schedule of Benefits. It is not a Covered Benefit under the Medical Expense Benefit. Any one prescription is limited to a ninety (90) day supply.

If the Member purchases a brand name drug when a generic drug equivalent is available, the Member will be required to pay the brand name Copayment, plus the difference between generic and brand name; unless the physician has issued a Dispense As Written.

SPECIALTY DRUG OPTION

The Plan also participates in a Specialty Drug Program to provide specialty medications to Members. It is required that Members use this program to obtain these specialty medications, which are most often self-injectables. All prescriptions filled through the Specialty Drug Program are limited to a 31-day supply per fill. To determine if the medication you are prescribed is part of the Specialty Drug Program, or for more information, please contact BriovaRxat 855-427-4682.

COVERED PRESCRIPTION DRUGS

1. All drugs prescribed by a physician that require a prescription either by federal or state law, except injectables (other than insulin) and drugs excluded by the Plan.
2. All compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.
3. Insulin when prescribed by a physician.
4. Allergy serums.
5. Oral, injectable, patch or emergency contraceptives. Also included are contraceptive implants and diaphragms.
6. Immunization agents.
7. A charge for prescription drugs for smoking cessation purposes, including smoking deterrent patches.
8. Epi-pens.
9. Diabetic supplies including but not limited to, blood glucose meters, insulin syringes including pen needles, insulin injecting devices, and glucagons-autoinjection.
10. Specialty drugs, including self-injectables.

11. Pediatric and prenatal federal legend vitamins, folic acid, iron supplements and Vitamin D supplements (age 65 and older).

12. A charge for smoking cessation prescription drugs or medications containing nicotine, including smoking deterrent patches or other smoking deterrent aides.
13. A charge for Attention-Deficit Disorder and Narcolepsy drugs up through age twenty-five (25).

LIMITS TO THIS BENEFIT

This benefit applies only when a Member 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.

PRESCRIPTION EXCLUSIONS

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin.
2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.
3. Biological sera, blood or blood plasma.
4. A drug or medicine labeled: “Caution - limited by federal law to investigational use.”
5. Experimental drugs and medicines, even though a charge is made to the Member including DESI drugs (drugs determined by the FDA as lacking substantial evidence of effectiveness.)
6. Any charge for the administration of a covered prescription drug.
7. Any drug or medicine that is consumed or administered at the place where it is dispensed.
8. A drug or medicine that is to be taken by the Member, in whole or in part, while hospital confined. This includes being confined in any institution that has a facility for dispensing drugs.
9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.
10. A charge for infertility medication.
11. A charge for legend vitamins, except as stated above.
12. A charge for minerals.
13. A charge for fluoride supplements.
14. A charge for weight loss drugs.
15. A charge for Tretinoin, all dosage forms for Members over age twenty-five (25).
16. A charge for non-legend drugs, other than as specifically listed herein.
17. A charge for Hematinics.
18. A charge for pregnancy termination drugs.
19. A charge for sexual dysfunction drugs.

ELIGIBILITY

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

EMPLOYEE ELIGIBILITY

All employees regularly scheduled to work at least [thirty (30)] hours per work week shall be eligible to enroll for coverage under this Plan. <This does not include temporary or seasonal employees>.

DEPENDENT ELIGIBILITY

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

1. Spouse:

The term "spouse" means the spouse of the employee under a legally valid existing marriage, unless court ordered separation exists; or

2. Domestic Partner:

The term "Domestic Partner" means a person of the same sex with whom the employee has established a Domestic Partnership.

Domestic Partnership is a relationship between an Employee and one other person of the opposite or same sex. All of the following requirements apply to both persons:

A. They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
B. They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
C. They must share the same permanent residence and the common necessities of life.
D. They must be at least 18 years of age.
E. They must be mentally competent to consent to contract.
F. They must be financially interdependent and they have furnished documents to support at least two of the following conditions of such financial interdependence:
    i. They have a single dedicated relationship of at least 6 months duration.
    ii. They have joint ownership of a residence.
    iii. They have at least two of the following:
        a) A joint ownership of an automobile.
        b) A joint checking, bank or investment account.
        c) A joint credit account.
        d) A lease for a residence identifying both partners as tenants.
        e) A will and/or life insurance policies which designates the other as primary beneficiary.

The Employee and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

3. **Child/Children:**

The term "Child/Children" means the employee's natural child, stepchild, legally adopted child, foster child, and a child for whom the employee or covered spouse has been appointed legal guardian, provided the child has not reached the end of the month of his or her twenty-sixth (26^{th}) year of age.

4. **Qualified Medical Child Support Order (QMCSO):**

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

Child Support Order or a National Medical Support Notice (NMSN) as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

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

5. Adopted Children:

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

6. **Developmentally or Physically Disabled Child:**

A child who is unmarried, incapable of self-sustaining employment, and dependent upon the employee for support due to a mental and/or physical disability, and who was covered under the Plan prior to reaching the maximum age limit or other loss of dependent's eligibility, will remain eligible for coverage under this Plan beyond the date coverage would otherwise be lost.

Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the employer or Claims Administrator, but not more than once every two (2) years.

Eligibility may not be continued beyond the earliest of the following:

A. Cessation of the mental and/or physical disability;
B. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination;
C. Eligible dependents do not include:
    i. A spouse who is legally separated or divorced from the employee. Such spouse must have met all requirements of a valid separation or divorce decree.
    ii. Children of a dependent son or daughter.
    iii. Children who are, or become, a full-time member of the armed forces of any country.
    iv. Any person who is covered as a dependent of another employee under this Plan.
    v. Any person who is eligible as an employee under the Plan.
    vi. The spouse of a dependent child.

ENROLLMENT

The benefits of this Plan are based on a benefit year. If an employee or dependent enrolls for coverage at any time during the benefit year, the benefits shall be calculated on a benefit year

APPLICATION FOR ENROLLMENT

An employee must file a written application with the employer for coverage hereunder for himself and his eligible dependents within thirty-one (31) days of becoming eligible for coverage; and within thirty-one (31) days of marriage or the acquiring of children or birth of a child. The employee shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder. Once a properly completed application for enrollment has been submitted to the employer and coverage has become effective, as defined in the section titled, Effective Date of Coverage, the employee's enrollment options shall remain in effect. The only opportunity to change the enrollment option shall be at the annual open enrollment period, or upon a Special Enrollment option as defined below.

The employer must be notified of any change in eligibility of dependents within thirty-one (31) days of the change, including the birth of a child that is to be covered and adding or deleting any other dependents. Forms are available from the employer for reporting changes in dependents' eligibility as required.

Failure to complete the application for enrollment within thirty-one (31) days shall result in the Late Enrollment provision applying to the individual. An alternate recipient can be enrolled in the Plan at any time and shall not be subject to the Late Enrollment provision.

Employee/Spouse Enrollment

Every eligible employee may enroll eligible dependents. However, if both the husband and wife or domestic partner are employees, each individual will be covered as an employee. An employee cannot be covered as an employee and a dependent. Eligible children may be enrolled as dependents of one spouse, but not both.

Transfer of Coverage

If a husband and wife are both employees and are covered as employees under this Plan and one of them terminates, the terminating spouse and any of the eligible enrolled children will be permitted to immediately enroll under the remaining employee's coverage. Such new enrollment will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the employee or the dependent of the terminated employee.

SPECIAL ENROLLMENT PERIOD: LOSS OF ELIGIBILITY FOR OTHER COVERAGE

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

1. Termination of the other coverage (including exhaustion of COBRA benefits)
2. Cessation of employer contributions toward the other coverage
3. Legal separation or divorce
4. Termination of other employment or reduction in number of hours of other employment
5. Death of spouse who had the coverage under the other plan.

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

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

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

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

SPECIAL ENROLLMENT PERIOD: DEPENDENT ACQUISITION

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

1. Marriage
2. Birth of a dependent child
3. Adoption or placement for adoption of a dependent child

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

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

1. In the case of marriage, the first day of the first calendar month following the employer's receipt of the completed enrollment form;
2. In the case of a dependent's birth, the date of such birth;
3. In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

SPECIAL ENROLLMENT PERIOD: MEDICAID AND CHIP ELIGIBILITY

An eligible employee, or an employee's eligible dependent, who is not enrolled under the Plan, shall be permitted to enroll for coverage hereunder if either of the following conditions is met:

1. Termination of Medicaid or CHIP Coverage: If the employee or dependent is covered under a State Medicaid plan under Title XIX of the Social Security Act, or under a State Child Health Plan under Title XXI of the Social Security Act, and coverage of the employee or dependent under such coverage is terminated as a result of loss of eligibility for such coverage.
2. Eligibility for Premium Assistance Under Medicaid or CHIP: If the employee or dependent becomes eligibility for premium assistance, with respect to coverage under the Plan, under a Medicaid plan or State Child Health Plan.

The employee or dependent must submit a complete application for enrollment to the employer within sixty (60) days of either: (1) termination of coverage under such other coverage, or (2) the date the employee or dependent is determined to be eligible for premium assistance. Failure to submit the completed application for enrollment within the designated time shall result in the employee's or dependent's forfeiture of this enrollment right and shall be subject to enrolling upon the next open enrollment period sponsored by the employer.

OPEN ENROLLMENT

Open enrollment is the period designated by the employer during which the employee may elect coverage for himself and any eligible dependents if he is not covered under the Plan and does not qualify for a Special Enrollment as described herein. Enrolled employees may add or drop coverage for dependents during this open enrollment period.

An open enrollment will be permitted once in each benefit year during a period selected by employer. Coverage changes shall be effective on the first day of the month following the open enrollment period provided a properly completed application for enrollment is submitted to the employer during the designated open enrollment period and must be received by the employer by the last day of the open enrollment period.

LATE ENROLLMENT

With the exception of the provisions identified in Special Enrollment above, applications for employee or dependent coverage which are not filed with the employer within thirty-one (31) days of meeting the eligibility requirements of the Plan shall be subject to this late enrollment provision.

Late enrollment applicants shall be eligible to enroll for coverage during the Plan's annual open enrollment period. Coverage shall be effective the first of the month following the open enrollment period provided a properly completed application for enrollment has been received by the employer. This late enrollment provision shall not apply to an alternate recipient.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE EFFECTIVE DATE

Eligible employees, as described in Eligibility, are covered under the Plan the [first of the month coincident with or following 60 days of employment]; provided a properly completed enrollment form was submitted to the employer.

In the event a part-time employee changes employment status to full-time, coverage will be effective on the date the employee meets the Plan's eligibility requirements, provided the employee worked in a part-time capacity for the employer for at least the period of time equal to the Plan's waiting period.

If the employee does not enroll for coverage within thirty-one (31) days of meeting the Plan's eligibility requirements, the effective date of coverage will be delayed. Refer to Enrollment.

DEPENDENT EFFECTIVE DATE

Eligible dependents, as described in Eligibility, will become covered under the Plan on the later of the dates listed below, provided the employee has enrolled them in the Plan within thirty-one (31) days of meeting the Plan's eligibility requirements. If the employee does not enroll eligible dependents within thirty-one (31) days of meeting the Plan's eligibility requirements, the dependents' effective date of coverage will be delayed. Refer to Enrollment.

1. The date the employee's coverage becomes effective.
2. The date the dependent is acquired, provided any required contributions are made and the employee has applied for dependent coverage within thirty-one (31) days of the date acquired.
3. Newborn children shall be covered as follows:
   A. If the employee is enrolled for family coverage and paying the required contributions, a newborn shall be covered from birth. An application for enrollment must be submitted to the employer for administrative purposes.
   B. If the employee is enrolled for single coverage, an application for enrollment must be submitted to the employer within thirty-one (31) days of birth for coverage to be effective as of the date of birth. If the application for enrollment is received more than thirty-one (31) days following birth, the newborn will be subject to the Plan's Late Enrollment provision.
4. Coverage for a newly adopted child shall be effective on the date the child is placed for adoption.

TERMINATION OF COVERAGE

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

EMPLOYEE TERMINATION DATE

1. The date the employer terminates the Plan whether or not the employer offers a different plan.
2. The last day of the month in which the employee ceases to meet the eligibility requirements of the Plan.
3. The last day of the month in which employment terminates.
4. The date the employee becomes a full-time, active member of the armed forces of any country.
5. Midnight on the first day after the date any required contribution is due but not paid, unless the Member has received confirmation in writing from a representative of the Plan that coverage will not be terminated.
6. The date the employee fails to return from an approved leave of absence.
7. At any time, coverage may be rescinded, or retroactively terminated, effective the date the employee commits or has committed an intentional act of fraud or material misrepresentation with respect to the Plan, with 30 days written notice from the Plan.

DEPENDENT TERMINATION DATE

1. The date the employer terminates the Plan and offers no other group health plan.
2. The date the employee's coverage terminates. However, if the employee remains eligible for the Plan, but elects to discontinue coverage, coverage may be extended for alternate recipients.
3. The date such person ceases to meet the eligibility requirements of the Plan.
4. Midnight on the first day after the date any required contribution is due but not paid, unless the Member has received confirmation in writing from a representative of the Plan that coverage will not be terminated.
5. The date the dependent becomes a full-time, active member of the armed forces of any country.
6. The date the Plan discontinues dependent coverage for any and all dependents.
7. The last day of the month in which the dependent becomes eligible as an employee.
8. At any time, coverage may be rescinded, or retroactively terminated, effective the date the employee commits or has committed an intentional act of fraud or material misrepresentation with respect to the Plan, with 30 days written notice from the Plan.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for employees and/or dependents, when the employee is on an authorized leave of absence from the employer. In no event will coverage continue for more than ninety (90) days after the employee's active service ends. If the employee fails to return to work after an approved leave of absence, any time applied toward the approved leave of absence shall apply concurrently toward the continuation of coverage provision under COBRA.

ADMINISTRATIVE LEAVE

Coverage will continue for any employee and/or dependents, where the employee is placed on Administrative Leave by the employer. The employer shall continue to pay the applicable contributions for coverage for the employee and/or dependent’s coverage. Such coverage under the Plan shall continue until the investigation of the employee is brought to a close. Should the result of the investigation prove improper action on the part of the employee and the decisions is to suspend the employee for a duration of time less than thirty (30) days; the Plan will continue to provide coverage during the Administrative suspension.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An employee who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this Plan for up to twelve (12) weeks during any twelve (12) month period.

Contributions

During this leave, the employer will continue to pay the same portion of the employee's contribution for the Plan. The employee shall be responsible to continue payment for eligible dependent's coverage and any remaining employee contributions. If the covered employee fails to make the required contribution during a FMLA leave within thirty-one (31) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement

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

Repayment Requirement

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

EMPLOYEE REINSTATEMENT

Employees and eligible dependents that lost coverage due to an approved leave of absence, layoff, or termination of employment with the employer are eligible for reinstatement of coverage as follows:

1. Reinstatement of coverage is available to employees and dependents that were previously covered under the Plan.
2. Rehire or return to work must occur within ninety (90) days of separation of employment.
3. The employee must submit the completed application for enrollment to the employer within thirty-one (31) days of rehire or return to work.
4. Coverage shall be effective from the date of rehire. Prior benefits and limitations, such as Deductible and Maximum Benefit Amount shall be applied with no break in coverage.

If the provisions of (1) through (3) above are not met, the Plan's provisions for eligibility and application for enrollment shall apply.

An employee who returns to work after ninety (90) days of an approved leave of absence, layoff, or separation of employment will be considered a new employee for purposes of eligibility and will be subject to all eligibility requirements.

CONTINUATION OF COVERAGE

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

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

QUALIFYING EVENTS

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

1. Death of the employee.
2. The employee's termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the Plan.
3. Divorce or legal separation from the employee.
4. The employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
5. A dependent child no longer meets the eligibility requirements of the Plan.
6. The last day of leave under the Family Medical Leave Act of 1993.
7. The call-up of an employee reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered employee, or a child's loss of dependent status, the employee or dependent must notify the employer of that event within sixty (60) days of the event. The employee or dependent must advise the date and nature of the qualifying event and the name, address and Social Security number of the affected individual. Failure to provide such notice to the employer will result in the person forfeiting their rights to continuation of coverage under this provision.
2. The employer has thirty (30) days to notify the Claims Administrator of the qualifying event. Within fourteen (14) days of receiving notice of the qualifying event, the COBRA administrator will notify the employee or dependent of his right to continuation of coverage, and what process is required to elect continuation of coverage.
3. After receiving notice, the employee or dependent has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the Plan prior to the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. The COBRA Administrator must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the latter of the following:
   A. The date coverage under the Plan would otherwise end; or
   B. The date the person receives the notice from the employer of his or her rights to continuation of coverage.
4. Within forty-five (45) days after the date the person notifies the COBRA Administrator that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day each month.
5. The employee or dependent must make payments for the continued coverage.

COST OF COVERAGE

1. The employer requires that Members pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. This must be remitted to the COBRA Administrator, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.
2. For purposes of determining monthly costs for continued coverage, a person originally covered as an employee or as a spouse will pay the rate applicable to an employee if coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to an employee.

WHEN CONTINUATION COVERAGE BEGINS

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

Since a reduction in employment hours is a qualifying event under this provision, any continuation of coverage granted by the employer (leave of absence, layoff, Family Medical Leave Act) shall run simultaneously with the continuation of coverage provided under this provision (COBRA).

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

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

SUBSEQUENT QUALIFYING EVENTS

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

1. Death of an employee,
2. Divorce or legal separation from an employee,
3. Employee's entitlement to Medicare, or
4. The child's loss of dependent status.

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

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

END OF CONTINUATION

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

1. Eighteen (18) months from the date continuation began because of a reduction of hours or termination of employment of the employee.
2. Thirty-six (36) months from the date continuation began for dependents whose coverage ended because of the death of the employee, divorce or legal separation from the employee, or the child's loss of dependent status.
3. The end of the period for which contributions are paid if the Member fails to make a payment on the date specified by the employer.
4. The date coverage under this Plan ends and the employer offers no other group health benefit plan.
5. The date the Member first becomes entitled to Medicare after the date of election of COBRA continuation coverage.
6. The date the Member first becomes covered under any other group health plan after the date of election of COBRA continuation coverage.

EXTENSION FOR DISABLED INDIVIDUALS

A person who is totally disabled may extend continuation coverage from eighteen (18) months to twenty-nine (29) months. The person must be disabled for Social Security purposes at the time of the qualifying event or within sixty (60) days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the COBRA Administrator within the initial eighteen (18) month continuation coverage period and no later than sixty (60) days after the Social Security Administration's determination. The disabled person and the family members who were covered prior to the qualifying event are eligible for up to twenty-nine (29) months of continuation of coverage. The employer may charge 150% of the contribution during the additional eleven (11) months of continuation of coverage. Extended coverage will end on the month that begins thirty (30) days after the person is no longer considered disabled.

MILITARY MOBILIZATION

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

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

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

1. Twenty-four (24) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the employee fails to return to employment within the time allowed.

Whether or not the individual elects continuation of coverage under USERRA, upon return from uniformed services, the employee or the employee’s dependent coverage will be reinstated the date of return to work, provided the uniformed service member was released under honorable conditions, and returns to work within the following timelines:

1. Following completion of the military service for a leave of less than thirty-one (31) days, upon the first full regularly scheduled work period after the expiration of eight (8) hours after a period allowing for the save transportation of the person from the place of service to the person’s residence;
2. Within fourteen (14) days of completing military services for a leave of thirty-one (31) days to one hundred eighty (180) days;
3. Within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days.

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

CLAIM FILING PROCEDURE

FILING A CLEAN CLAIM

Whenever you incur an expense for treatment covered under the Plan, an itemized bill for services should be submitted to the claim address printed on your identification card. Appropriate forms for filing claims can be obtained from your employer. Your provider may file claims for you by submitting the following:

- Current version of CMS–1500 and UB-04

Generally, a Provider will submit claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Claims Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Benefits as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Member or Provider has failed to submit required forms or additional information to the Plan as well.

The Member may ask the provider to file a claim form. However, it is ultimately the member's responsibility to make sure the claim has been filed for benefits.

FOREIGN CLAIMS

In the event a Member incurs a Covered Benefit in a foreign country, the Member shall be responsible for providing the following to the Claims Administrator before payment of any benefits due are payable:

1. The claim form, provider invoice and any other documentation required to process the claim must be submitted in the English language.
2. The charges for services must be converted into dollars.
3. A current conversion chart validating the conversion from the foreign country's currency into dollars.

TIME LIMIT FOR FILING ALL CLAIMS

A claim for benefits should be submitted to the Claims Administrator within ninety (90) days after the occurrence or commencement of any services covered by the Plan, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce any claim if the Member submits proof to the Plan Administrator that: (1) it was not reasonably possible to file a claim within that time; (2) and that such claim was furnished as soon as possible, but no later than twelve (12) months after the loss occurs or commences, unless the claimant is legally incapacitated.

Notice given by or on behalf of a Member or his beneficiary, if any, to the Plan Administrator or to any authorized agent of the Plan with information sufficient to identify the Member, shall be deemed notice of claim.

PAYMENT OF BENEFITS

After a claim has been submitted to the Claims Administrator, if additional information is needed for payment of the claim, the Claims Administrator will request the information. The Claims Administrator will approve or deny the claim within thirty (30) days after all necessary information is received by the Claims Administrator to determine the validity of the claim. This time period may be extended for fifteen (15) days if it is necessary because of matters beyond the Plan's control, and if the Plan notifies the Member of those circumstances and the expected date of decision before the end of the thirty (30) days period. This Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. The Member and/or Provider will be allowed up to ninety (90) calendar days from receipt of the Notice of Extension to provide the additional information. The Plan will then make a claim determination within a reasonable period, but not later than fifteen (15) calendar days from the date the additional information is received.

In the event a claim for benefits under the Plan is denied in whole or in part, the Member will receive written notification stating the required information including the review procedure, in the same fashion as reimbursement for a claim, in a manner calculated to be understood by the Member. A claim worksheet will be provided by the Claims Administrator showing the calculation of the total amount payable, charges not payable, and the reason.

EXPLANATION OF PAYMENT

Benefits available to Providers are limited such that if a Provider advances or submits claims which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

If the charge billed by a Provider for any Covered Charge is higher than the Maximum Allowable Amount determined by the Plan, the Member is responsible for the excess unless the Provider accepts an Assignment of Benefits as consideration in full for services rendered. When Participating Providers have agreed to accept a negotiated discounted fee as full payment for their services, The Member is not responsible for any billed amount that exceeds that fee.
Providers accepting an Assignment of Benefits shall do so as consideration in full for services rendered, and send the Member's claims directly to the Third Party Administrator. The Plan will pay the scheduled benefit amount, less any required deductibles and copayments, and subject to any limits or exclusions, directly to the Provider.

When available, benefits will be limited by the terms of the Plan, including provisions which limit benefits to the Reasonable and Allowed amounts. The Plan will not pay any expense that is not a Covered Charge.

ASSIGNMENTS

Benefits for medical expenses covered under this Plan may be assigned by a Member to the Provider as consideration in full for services rendered. An Assignment of Benefits occurs when a Member assigns their right to submit a request for benefits to the Plan to a services Provider. Assignment of Benefits should be provided to a Provider, and accepted by a Provider, as payment in and of itself, for services rendered. As such, Assignment of Benefits is itself consideration from the Member to the Provider, and must be deemed payment in full in order to be achieved.

If benefits are paid directly to the Member, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

Note: By submitting a claim to the Claims Administrator, the Provider is expressly agreeing to these provisions, and to be bound by these and all other provisions of the Plan.

If a Provider refuses to accept an Assignment of Benefits as compensation in full for services rendered, the Assignment of Benefits will be payable to the Member and not the Provider. If benefits are paid directly to the Member, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. In that event, the Member will be responsible for, and in addition to any copayments, coinsurance, and deductibles, any amount above the Plan's Reasonable amount, up to the Provider's charges.

The Plan pays the percentage listed on the following pages for Covered Benefits at the Reasonable reimbursement level. The Member is responsible for the difference between the percentage the Plan paid and 100% for the negotiated rate for Providers. For Providers, the Member is responsible for the difference between the percentage of the Reasonable Charge reimbursement level and 100% of the billed amount. The Member's portion of the coinsurance represents the out-of -pocket expenses.

The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Member and the assignee, has been received before the proof of loss is submitted.

No Member shall, at any time, either during the time in which he or she is a Member in the Plan, or following his or her termination as a Member, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

If a Provider refuses to accept an Assignment of Benefits as compensation in full for services rendered, the Assignment of Benefits will be revoked and returned to the Member such that benefits will be payable to the Member and not the Provider. If benefits are paid directly to the Member, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits.

The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Member and the assignee, has been received before the proof of loss is submitted.

No Member shall at any time, either during the time in which he or she is a Member of the Plan, or following his or her termination as a Member, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

APPEALING A CLAIM

If you disagree with either a Pre-service request for Benefits determination or Post service claim determination, a Member has the right to Appeal a denial, limitation, reduction, suspension or termination of coverage for services.

There are two (2) types of Appeals: Pre-service and Post service.

The Member, a Member's representative or a Provider appealing on the Member's behalf may file a verbal or written Pre-Service appeal upon notification of the adverse action (for example, a denial of a claim or service).

A Post service appeal request must be submitted in writing.

A Member's representative or a Provider who is filing an appeal on behalf of the Member must have the Member's written consent prior to submitting the appeal to the Claims Administrator.

An Appeal must be filed within 180 calendar days from the date of the event giving rise to the Appeal.

1. Your request for an appeal should include:

   A. The Member's name and the identification number from the ID card.
   B. The date(s) of scheduled medical service(s) or the date the service was rendered.
   C. The provider's name.
   D. The reason you believe the determination should be reversed.
   E. Any documentation or other written information to support your request for reconsideration.

2. A qualified committee who was not involved in the decision being appealed will be appointed to decide the appeal.

3. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts including an Independent External Reviewer as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical information.

4. In cases of denied pre-service requests for Benefits where a Physician certifies that a delay in receiving the services will result in a significant negative impact to your medical condition, you or your representative may request an expedited medical review. If it is determined that the Appeal should be expedited based on medical need (imminent and serious threat to the health of the Member), the Claims Administrator will request any necessary additional clinical information, and make a determination as soon as possible, but not more than 24 hours following the request, based on the available clinical information.

5. For a non-expedited (standard) appeal request, the Claims Administrator will respond within 60 calendar days of receiving all of the information needed to conduct the review.

6. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your request for Benefits or claim payment including, but not limited to, the information considered and relied upon in making the adverse benefit determination or final internal adverse benefit determination.

7. Once the internal appeal process is exhausted, if not satisfied with the Claims Administrator's response to the Appeal, the Member has the right to an Independent External Review of an adverse Appeal decision. Generally, the use of an Independent External Reviewer for adverse Appeal decision is based on a

determination that the services were Experimental, Investigational, or Unproven Health Care or that there was a lack of Medical Necessity for the proposed or performed medical, surgical, or traumatic dental services involved, but may be related to other adverse Appeal decisions.

8. The external review will be made by an independent review organization with health care professionals that they have no conflict of interest with respect to the benefit determination.

9. To file an independent external review you must submit your request in writing to the Claims Administrator within 4 months (120 days) after date of receipt of notice of an adverse determination.

10. Upon request the Claims Administrator will provide a copy of the full independent external review policy and procedure, including information on how to initiate the appeal, and the contact information for any applicable health insurance consumer assistance or ombudsman established by law to assist individuals with the internal claim and appeal processes and external review processes.

11. The independent external reviewer's decision is final and legally binding on the Member and the Claims Administrator even if you or we disagree with the decision.

COORDINATION OF BENEFITS

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

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

DEFINITIONS APPLICABLE TO THIS PROVISION

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

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

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

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

1. Group insurance or any other arrangement for coverage for Members in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;
2. Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
5. Any coverage under a government program and any coverage required or provided by any statute;
6. Group automobile insurance;
7. Individual automobile insurance coverage;
8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;
9. Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;
10. Labor/management trustee, union welfare, employer organization, or employee benefit organization plans.

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

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

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a Member for each claim determination period for the Allowable Expenses. If this Plan is secondary, the benefits paid under this Plan may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expense.

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

ORDER OF BENEFIT DETERMINATION

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

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

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

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

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

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

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

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

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

COORDINATION WITH MEDICARE

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

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

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

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

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

5. A Covered Person that is an active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If

coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

6. To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). The Member will be assumed to have full Medicare coverage (that is, both Parts A & B) whether or not the Member has enrolled for the full coverage. If the Provider accepts assignment with Medicare, covered expenses will not exceed the Medicare approved expenses.

7. If any Member is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

This section is subject to the standard terms of the Medicare Secondary Payor laws and regulations, including but not limited to, determination of first and second payor for a person with End Stage Renal Disease, or a person eligible for Medicare due to disability. Any changes in these related laws and regulations will apply to the provisions of this section.

LIMITATIONS ON PAYMENTS

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

FACILITY OF BENEFIT PAYMENT

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

SUBROGATION

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, or Disease or Disability is caused in whole or in part by, or results from the acts or omissions of Members, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Member(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Member(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Member(s) agrees the Plan shall have an equitable lien on any funds received by the Member(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Member(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Member(s) settles, recovers, or is reimbursed by any Coverage, the Member(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Member(s). If the Member(s) fails to reimburse the Plan out of any judgment or settlement received, the Member(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Member(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Member(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Member(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Member(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Member(s) may have against any Coverage and/or party causing the Injury, Illness, or Disease to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the Member(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Member(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

Then the Member(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Member(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Member(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Plan shall be entitled to recover one hundred percent (100%) of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Member(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Member(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Member(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Member(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Injury, Illness, or Disease or Disability.

EXCESS INSURANCE

If at the time of Injury, Illness, or Disease or Disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Member(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Member(s), such that the death of the Member(s), or filing of bankruptcy by the Member(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Member(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Member(s) and all others that benefit from such payment.

OBLIGATIONS

It is the Member(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
2. To provide the Plan with pertinent information regarding the Injury, Illness, or Disease or Disability, , including accident reports, settlement information and any other requested additional information;
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
6. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Member may have against any responsible party or Coverage.

If the Member(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury, Illness, or Disease or condition, out of any proceeds, judgment or settlement received, the Member(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Member(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Member(s)' cooperation or adherence to these terms.

OFFSET

If timely repayment is not made, or the Plan Member and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Member's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Member(s) in an amount equivalent to any outstanding amounts owed by the Plan Member to the Plan.

MINOR STATUS

In the event the Member(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

GENERAL PROVISIONS

PLAN ADMINISTRATOR AND FIDUCIARY

[ABC Company] shall be the Plan Administrator and named Fiduciary of this Plan and as such, has the authority to control and manage the operation and administration of the Plan. The Plan Administrator intends to continue the Plan indefinitely, but reserves the right to terminate or amend the Plan in any way. No consent of any covered person or any other person referred to in the Plan will be required to terminate, modify, amend or change the Plan. The Plan Administrator may amend any provision, condition, limitation or exclusion of the Plan. Notice will be given to all covered employees within 60 days after the date of adoption of the modification or change. No agent is authorized to modify the Plan.

ASSIGNMENT

The Plan will pay benefits under this Plan to the employee unless payment has been assigned to a hospital, physician, or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the Plan unless the Claims Administrator is notified in writing of such assignment prior to payment hereunder. This Plan will pay benefits to the responsible party of an alternate recipient as designated in a qualified medical child support order.

Participating Providers normally bill the Plan directly. If services, supplies or treatment has been received from such a provider, benefits are automatically paid to that provider. The Member's portion of the negotiated rate, after the Plan's payment, will then be billed to the Member by the Participating Provider.

BENEFITS NOT TRANSFERABLE

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

CLERICAL ERROR

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

CONFORMITY WITH STATUTE(S)

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

EFFECTIVE DATE OF THE PLAN

The Effective Date of the Plan is [Month Date, Year].

FREE CHOICE OF HOSPITAL AND PHYSICIAN

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

INCAPACITY

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

INCONTESTABILITY

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

LEGAL ACTIONS

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

LIMITS ON LIABILITY

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

LOST DISTRIBUTEES

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

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

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

MISREPRESENTATION

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

PLAN IS NOT A CONTRACT

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

PLAN MODIFICATION AND AMENDMENT

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

An amendment to the Plan may be retroactively effective, but shall not adversely affect the rights of Members under this Plan for Covered Benefits provided after the effective date of the amendment but before the amendment is adopted.

Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the employer, or a written copy thereof shall be deposited with such master copy of the Plan.

PLAN TERMINATION

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

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

PRONOUNS

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

RECOVERY FOR OVERPAYMENT

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

SECONDARY COVERAGE

Covered Persons who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Covered Person incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which are payable by such secondary coverage when said coverage is primary, except to the extent that such costs are payable in any event by the Plan.

STATUS CHANGE

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

TIME EFFECTIVE

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

WORKERS' COMPENSATION NOT AFFECTED

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

DEFINITIONS

Alternate Recipient

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

Ambulatory Surgical Facility

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

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an outpatient basis;
2. Provides treatment by or under the supervision of physicians and nursing services whenever the covered person is in the ambulatory surgical facility;
3. Does not provide inpatient accommodations; and
4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a physician.

Approved Clinical Trial

An "Approved Clinical Trial" is defined as:
A Phase I, Phase II, Phase III, or Phase IV clinical trial, being conducted in relation to the prevention, detection or treatment for cancer or other life threatening disease or condition, and that meets the requirements set forth within the plan document, see Clinical Trails

For purposes of this benefit, a "life-threatening disease or condition" is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted

Assignment of Benefits

An arrangement whereby the Member assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to any Provider. If the Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Member, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an Assignment of Benefits as consideration in full for services, supplies, and/or treatment rendered.

Benefit Year

The twelve-month period beginning [Month Date to Month Date] for which all Plan benefits shall be calculated. Any applicable Deductible, Out-of-Pocket maximum expense limit, or Maximum Benefit Amount shall accrue on a benefit year basis.

Birthing Center

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

1. It mainly provides an outpatient setting for childbirth following a normal, uncomplicated pregnancy, in a home-like atmosphere.
2. It has: (a) at least two (2) delivery rooms; (b) all the medical equipment needed to support the services furnished by the facility; (c) laboratory diagnostic facilities; and (d) emergency equipment, trays, and supplies for use in life threatening situations.
3. It has a medical staff that: (a) is supervised full-time by a physician; and (b) includes a registered nurse at all times when Members are at the facility.
4. If it is not part of a hospital, it has written agreement(s) with a local hospital(s) and a local ambulance company for the immediate transfer of Members who develop complications or who require either pre or post-natal care.
5. It admits only Members who: (a) have undergone an educational program to prepare them for the birth; and (b) have medical records of adequate prenatal care.
6. It schedules confinements of not more than twenty-four (24) hours for a birth.
7. It maintains medical records for each Member.
8. It complies with all licensing and other legal requirements that apply.

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

Case Management

A program of medical management typically utilized in situations involving extensive and on-going medical treatment, which provides a comprehensive and coordinated delivery of services under the oversight of a medically responsible individual or agency. Such programs may provide benefits not normally covered under the Plan provisions in lieu of inpatient hospital treatment.

Centers of Excellence

Medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Chemical Dependency

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

Chiropractic Care

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

Claims Administrator

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

Clean Claim

A Claim that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity, or fees under review for Reasonable and Allowed or any other matter that may prevent the charge(s) from being Covered Benefits in accordance with the terms of this document.

Close Relative

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

Coinsurance

The benefit percentage of Covered Benefits payable by the Plan for benefits that are provided under the Plan. The Coinsurance is applied to Covered Benefits after the Deductible(s) have been met, if applicable.

Complications of Pregnancy

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

1. Intra-abdominal surgery (but not elective Cesarean Section).
2. Ectopic pregnancy.
3. Toxemia with convulsions (Eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac Decompensation.

7. Missed Abortion.
8. Miscarriage.

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

Concurrent Review

A review by the Utilization Review Department which occurs during the Member's hospital confinement to determine if continued inpatient care is medically necessary.

Confinement

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

Copayment

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

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward or resulting in improvement or preservation of physical appearance, rather than to restore the anatomy and/or function of the body which are lost or impaired due to an illness or injury.

Covered Benefits

Medically necessary services, supplies or treatments, and payments for the same, that are recommended or provided by a physician, professional provider or covered facility for the treatment of an illness or injury and:

1. that are sought and provided in accordance with the terms of this document;
2. the charged amount for such services, supplies, or treatments does not exceed the Maximum Payable Amount;
3. that are not specifically excluded from coverage herein.

Covered Benefits applies to service type as well as charged amount.

Custodial Care

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

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

Deductible

A deductible is the dollar amount you pay for health care services before your plan begins to pay.

Dentist

A licensed doctor of dental medicine (D.M.D.) or a licensed doctor of dental surgery (D.D.S.), other than a close relative of the Member.

Dependents

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

Dialysis

HemoDialysis or peritoneal Dialysis and supplies.

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not used in the absence of an illness or injury;
4. Is appropriate for use in the home.

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

Effective Date

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

Emergency

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

1. Placing the Member's life in jeopardy, or
2. Causing other serious medical consequences, or
3. Causing serious impairment to bodily functions, or
4. Causing serious dysfunction of any bodily organ or part.

Employee

A person directly involved in the regular business of and compensated for services by the employer, who is regularly scheduled to work not less than [thirty (30)] hours per work week.

Employer

The employer is [ABC Company]

Enrollment Date

A Member's enrollment date is the first day of any applicable service waiting period or the date of hire.

Experimental/Investigational

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

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

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

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

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

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

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

Extended Care Facility

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

1. It is licensed to provide, and is engaged in providing, on an inpatient basis, for persons convalescing from illness or injury, professional nursing services, and physical restoration services to assist Members to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a registered nurse.
2. Its services are provided for compensation from its Members and under the full-time supervision of a physician or Registered Nurse.
3. It provides twenty-four (24) hour-a-day nursing services.
4. It maintains a complete medical record on each Member.
5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of mental and nervous disorders.
6. It is approved and licensed by Medicare.

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

Facility

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

Full-Time

Employee's regularly scheduled to work not less than [thirty (30)] hours per work week.

Generic Drug

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

Home Health Aide Services

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

Home Health Care Agency

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

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.
2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one physician and at least one Registered Nurse. It must provide for full-time supervision of such services by a physician or Registered Nurse.
3. It maintains a complete medical record on each Member.
4. It has a full-time administrator.
5. It qualifies as a reimbursable service under Medicare.

Hospice

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

1. It has obtained any required state or governmental Certificate of Need approval.
2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.
3. It is under the direct supervision of a physician.
4. It has a Nurse coordinator who is a Registered Nurse.
5. It has a social service coordinator who is licensed.
6. It is an agency that has as its primary purpose the provision of hospice services.
7. It has a full-time administrator.
8. It maintains written records of services provided to the Member.
9. It is licensed, if licensing is required.

Hospital

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to hospitals.
2. It is engaged primarily in providing medical care and treatment to ill and injured persons on an inpatient basis at the Member's expense.
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an illness or injury; and such treatment is provided by or under the supervision of a physician with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.
4. It qualifies as a hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.
5. It must be approved by Medicare.

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

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

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

A Hospital is considered a Facility for the purposes of this Plan.

Hospital Expenses

Charges by a Hospital for Room and Board (including private room accommodations) and/or for care in an Intensive Care Unit provided that such care is furnished at the direction of a Physician.

Hospital Miscellaneous Expenses

The actual charges made by a Hospital in its own behalf for services and supplies rendered to the Member which are Medically Necessary for the treatment of such Member. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Illness

A bodily disorder, disease, physical sickness, or pregnancy of a Member.

Incurred or Incurred Date

With respect to a Covered Benefit, the date the services, supplies or treatment are provided.

Injury

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

Inpatient

A confinement of a Member in a hospital, hospice, or extended care facility as a registered bed patient, for eighteen (18) or more consecutive hours and for whom charges are made for room and board.

Intensive Care

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

Intensive Care Unit

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

1. Facilities for special nursing care not available in regular rooms and wards of the hospital;
2. Special life saving equipment which is immediately available at all times;
3. At least two beds for the accommodation of the critically ill; and
4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

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

Late Enrollee

A Member who did not enroll in the Plan when first eligible or as the result of a Special Enrollment Period.

Layoff

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

Leave of Absence

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

Maximum Benefit Amount

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

1. The maximum amount paid by this Plan for any one Member during the entire time he is covered by this Plan.
2. The maximum amount paid by this Plan for any one Member for a particular Covered Benefit. The maximum amount can be for:
   A. The entire time the Member is covered under this Plan, or
   B. A specified period of time, such as a calendar year.
3. The maximum number the Plan acknowledges as a Covered Benefit. The maximum number relates to the number of:
   A. Treatments during a specified period of time, or
   B. Days of confinement, or
   C. Visits by a home health care agency.

Maximum Payable Amount, Maximum Amount, or Maximum Allowable Charge

Shall mean the benefit payable for a specific coverage item or benefit under the Plan.

The maximum allowable amount shall be calculated by the Plan Administrator taking into account and after having analyzed:

1. For Participating Provider covered services, the amount established in the agreement with the Preferred Provider Organization being made available to provide covered services
2. For Non-Participating Provider covered services
   - The Reasonable and Allowed amount as defined by the plan, or
   - The amount calculated based on the Plan's Reference-Based Price provisions; or
   - The charge otherwise specified under the terms of the Plan; or
   - Plan negotiated rates with provider(s); or

- An amount taking into consideration the findings or assessments of any, some, or all of the following:
  i. The National Medical Associations, Societies, and organizations; and
  ii. The Food and Drug Administration; as well as
  iii. Using objective and normative data such as, but not limited to,
    a) Medicare Rates,
    b) Cost information,
    c) Medicare Provider Reimbursement Manual et al, Manufacturer's wholesale pricing (MWP) and/or average wholesale price (AWP) for supplies, devices and/or prescriptions.

The Plan will reimburse the actual charge(s) if they are less than the Reasonable and Allowed amount(s). The Plan has the discretionary authority to decide if a charge is Reasonable and Allowed, as well as Medically Necessary.
In no event will the Maximum Payable Amount exceed benefits for the Maximum Benefit Amount. Certain services in the Schedule of Benefits are subject to specific limitations, and certain general limitations apply to benefits payable for all services. The Plan will take these limitations into account in calculating its Maximum Allowable Amount. The Maximum Payable will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medically Necessary (Medical Necessity)

Service, supply or treatment which, as determined by the employer/Plan Administrator, to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the Member's illness or injury and which could not have been omitted without adversely affecting the Member's condition or the quality of the care rendered;
2. In accordance with current standards of good medical practice within the organized medical community and is medically proven to be effective treatment of the illness or injury;
3. The most appropriate supply or level of service that can safely be provided to the Member. When applied to an inpatient admission, this further means that the Member requires acute care as a bed patient due to the nature of the services rendered or the Member's illness or injury, and the Member cannot receive safe or adequate care as an outpatient.

A service, supply, or treatment will not be considered medically necessary if:

1. It is provided only as a convenience to the Member or provider;
2. It is part of a plan of treatment that is experimental, unproven, or related to research protocol.

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

Medicare

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

Member

You and each eligible person listed on your application that is enrolled in the Plan sponsor's health plan.

Mental and Nervous Disorder

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

Negotiated Rate

The rate the Participating Providers have contracted to accept as payment in full for Covered Benefits of the Plan.

Nonparticipating Pharmacy

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

Non-Participating Provider

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

Nurse

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

Outpatient

A Member shall be considered to be an outpatient if he is treated at:

1. A hospital as other than an inpatient;
2. A physician's office, laboratory or x-ray facility; or
3. An ambulatory surgical facility; and

The stay is less than eighteen (18) consecutive hours.

Partial Confinement

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

1. Psychiatric services.
2. Treatment of mental and nervous disorders.
3. Alcoholism/Chemical dependency treatment.

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

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs and is contracted within the Pharmacy Organization.

Physician

A person duly licensed to practice medicine, to prescribe and administer drugs, or to perform surgery. This definition includes a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), Dentists, Podiatrists, Chiropractors, Psychologists, Psychiatrists provided that each, who is practicing within the scope of his license is permitted to perform services covered under this Plan and that this Plan does not exclude the services provided by such physician.

Placed For Adoption

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

Plan

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

Plan Administrator

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

Plan Sponsor

The Plan Sponsor is the employer.

PPACA

The Patient Protection and Affordable Care Act of 2010.

Participating Provider

A physician or ancillary provider who has an agreement in effect with the Participating Provider Organization at the time services are rendered. Participating Providers agree to accept the negotiated rate as payment in full.

Participating Provider Organization

An organization who selects and contracts with certain hospitals, physicians, and other health care providers to provide Members services, supplies and treatment at a negotiated rate.

Pregnancy

The physical state which results in childbirth or miscarriage.

Preventive Care

Preventive care services as recommended by the U.S. Preventive Task Force to include, but not limited to preventive screenings, immunizations, and pediatric care. For a complete listing, go to:

www.healthcare.gov/center/regulations/prevention/recommendations.html

Professional Provider

A person or other entity licensed where required and performing services within the scope of such license. The covered professional providers are:

1. Audiologist
2. Certified Addictions Counselor
3. Certified Registered Nurse Anesthetist
4. Certified Registered Nurse Practitioner
5. Chiropractor
6. Clinical Laboratory
7. Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)
8. Dental Hygienist
9. Dentist
10. Dietician
11. Dispensing optician
12. Midwife
13. Nurse (R.N., L.P.N., L.V.N.)
14. Occupational Therapist
15. Optician
16. Optometrist
17. Physical Therapist
18. Physician
19. Physician's Assistant
20. Podiatrist
21. Psychologist
22. Respiratory Therapist
23. Speech Therapist

Reasonable and Allowed

"Reasonable and Allowed" (R&A) shall mean Covered Expenses, necessary for the care and treatment of illness or injury not preventable yet not caused by the treating Provider, deemed to be eligible for payment by the Plan in the Plan Administrator's discretion, after taking into consideration findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration; as well as the fee(s) which Providers of similar training and experience in the same "area" most frequently charge the majority of patients for the service or supply, the amount Providers of similar training and experience in the same "area" accept from others as payment for the service or supply, the cost to the Provider for providing the services, and using objective and normative data such as, but not limited to, Medicare Rates, cost information, Medicare Provider Reimbursement Manual et al, manufacturer's wholesale pricing (MWP) and/or average wholesale price (AWP) for supplies, devices and/or prescriptions. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, zip code, state 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. The Reasonable and Allowed amount is based on <XXX>% of Medicare for facility, dialysis and ambulance services and XXX% of National Medicare for all other physician and

ancillary services, and must be in compliance with generally accepted billing practices for unbundling, multiple procedures, coding and billing guidelines.

"Reasonable and Allowed" and thus payable amounts may alternatively be determined by the Plan Administrator based upon rates negotiated by the Plan Administrator and Provider, before and/or after services and/or supplies are provided by the Provider.

The term "Reasonable and Allowed" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Member by a Provider. Charges for services, supplies, and/or treatments meant to treat or correct a preventable condition or cost which arises solely due to a Provider's medical error are not considered Covered Expenses or Reasonable and Allowed. The Plan Administrator will determine whether a specific procedure, service or supply is Reasonable and Allowed. 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

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Retrospective Review

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

Room and Board

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

Routine Nursery Care

Room and board, services, supplies and treatment for a newborn child while the mother is hospital confined due to delivery.

Semiprivate

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

Security Incidents

The term "Security Incidents" has the meaning set forth in 45 C.F.R.§ 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with systems operations in an information system. For the purpose of the Plan Sponsor's requirement to report any Security Incidents, only successful unauthorized access, use, disclosure, modification or destruction of information or interference with systems operations in an information system shall be included.

Total Disability or Totally Disabled

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

Treatment Center

1. An institution which does not qualify as a hospital, but which does provide a program of effective medical and therapeutic treatment for chemical dependency, and
2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or
3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:
   A. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.

B. It provides a program of treatment approved by the physician.

It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the Member.

C. It provides at least the following basic services:
   i. Room and board
   ii. Evaluation and diagnosis
   iii. Counseling
   iv. Referral and orientation to specialized community resources.

Utilization Review

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

Utilization Review

The individual or Department designated by the employer for the process of evaluating whether the service, supply, or treatment is medically necessary.

ADOPTION STATEMENT

[ABC Company] has caused this Employee Benefit Plan (Plan) to take effect as of the first day of [Month Date, Year] at [City, State].

I have read the document herein and certify the document reflects the terms and conditions of the employee benefit plan as established by [ABC Company].

Sign:_____

Print:_____

Date:_____