

TOWNSHIP OF PEMBERTON  
MEDICAL BENEFIT PLAN  
  
PLAN DOCUMENT  
AND  
SUMMARY PLAN DESCRIPTION

Effective Date: January 1, 2011

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# SUMMARY PLAN DESCRIPTION

**Name of Plan:**

Township of Pemberton Medical Benefit Plan

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

Township of Pemberton  
500 Pemberton-Browns Mill Road  
Pemberton, New Jersey 08068-1539  
609-894-3304

**Employer Identification Number:**

21-6007467

**Plan Number:**

501

**Group Number:**

626

**Type of Plan:**

Welfare Benefit Plan: medical, dental and prescription drug benefits

**Type of Administration:**

Contract administration; The processing of claims for benefits under the terms of the *Plan* is provided through one or more companies contracted by the *employer* and shall hereinafter be referred to as the *claims processor*.

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

Township of Pemberton  
500 Pemberton-Browns Mill Road  
Pemberton, New Jersey 08068-1539  
609-894-3304

Legal process may be served upon the *plan administrator*.

**Eligibility Requirements:**

For detailed information regarding a person's eligibility to participate in the *Plan*, refer to the following section:  
*Eligibility, Enrollment and Effective Date*

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

*Schedule of Benefits*  
*Pre-Existing Conditions*  
*Termination of Coverage*  
*Plan Exclusions*

**Source of Plan Contributions:**

Contributions for *Plan* expenses are obtained from the *employer* and from covered *employees*. The *employer* determines the amount to be contributed by the covered *employees*, based on local ordinances, state statutes, and collective bargaining agreements where applicable.

**Funding Method:**

The *employer* pays *Plan* benefits and administration expenses directly from general assets. Contributions received from *covered persons* are used to reduce *Plan* costs in accordance with state law.

**Ending Date of Plan Year:**

December 31

**Procedures for Filing Claims:**

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

CoreSource, Inc.  
P.O. Box 2920  
Clinton, IA 52733-2920

Except as otherwise provided herein, the designated *claims processor* for claims and benefits under the *Prescription Drug Program* is:

Caremark  
211 Commerce Street, Suite 800  
Nashville, TN 37201

**Statement of ERISA Rights:**

Participants in the *Plan* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

1. 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, if applicable.
2. Obtain, upon written request to the *plan administrator*, copies of documents governing the operation of the *Plan*, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description, if applicable. The *plan administrator* may make a reasonable charge for the copies.
3. Receive a summary of the *Plan's* annual financial report. The *plan administrator* is required by law to furnish each participant with a copy of this summary annual report, if applicable.
4. Continue health care coverage for the participant, the participant's spouse or *dependents* if there is a loss of coverage under the *Plan* as the result of a qualifying event. The participant or *dependent* may have to pay for such coverage. Review this summary plan description and the documents governing the *Plan* on the rules governing COBRA continuation coverage rights.
5. Reduction or elimination of exclusionary periods of coverage for *pre-existing conditions* under the *Plan*, if the participant or *dependent* has creditable coverage from another plan. The participant or *dependent* should be issued a certificate of coverage when coverage under the *Plan* is lost; when the participant or

*dependent* becomes entitled to elect COBRA continuation coverage; when COBRA coverage ceases; if a certificate is requested before losing coverage, or if a certificate is requested within twenty-four (24) months after losing coverage. The participant or *dependent* may be subject to a *pre-existing condition* exclusion for twelve (12) months after the *enrollment date* for coverage. The participant or *dependent* should be provided a certificate of creditable coverage, free of charge, from their group health *Plan* or health insurance insurer.

In addition to creating rights for *Plan* participants, ERISA imposes obligations upon the people who are responsible for the operation of the *Plan*. The people who operate the *Plan*, called "fiduciaries" of the *Plan*, have a duty to do so prudently and in the interest of all *Plan* participants.

No one, including the *employer*, a union, or any other person, may fire an *employee* or discriminate against an *employee* to prevent the *employee* from obtaining any benefit under the *Plan* or exercising their rights under ERISA.

If claims for benefits under the *Plan* are denied, in whole or in part, the participant must receive a written explanation of the reason for the denial. The participant has the right to have the *Plan* review and reconsider the claim.

Under ERISA, there are steps participants can take to enforce their rights. For instance, if material is requested from the *Plan* and the material is not received within thirty (30) days, the participant may file suit in a federal court. In such case, the court may require the *plan administrator* to provide the materials and pay the participant up to \$110 a day until the materials are received, unless the materials were not provided for reasons beyond the control of the *plan administrator*. If a claim for benefits is denied or ignored in whole or in part and after exhaustion of all administrative remedies, the participant may file suit in a state or federal court.

If it should happen that *Plan* fiduciaries misuse the *Plan's* money, or if participants are discriminated against for asserting their rights, participants may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who will pay the costs and legal fees. If the participant is successful, the court may order the person who is sued to pay these costs and fees. If the participant loses, the court may order the participant to pay the costs and fees; for example, if it finds the participant's claim frivolous.

Participants should contact the *plan administrator* for questions about the *Plan*. For questions about this statement or about rights under ERISA, participants should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in their 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.

# AETNA PREFERRED PROVIDER OR NONPREFERRED PROVIDER

*Covered persons* have the choice of using either an *Aetna Preferred Provider* or a *nonpreferred provider*.

## AETNA PREFERRED PROVIDERS

An *Aetna Preferred Provider* is a *physician, hospital* or ancillary service provider which has an agreement in effect with Aetna to accept a reduced rate for services rendered to *covered persons*. This is known as the *negotiated rate*. The *Aetna Preferred Provider* cannot bill the *covered person* for any amount in excess of the *negotiated rate*. *Covered persons* should contact the *employer's* Human Resources Department for a current listing of *Aetna Preferred Providers*.

The *Aetna negotiated rate* is only available for medical services, treatment or supplies that are a *covered expense* under this *Plan*.

The *Aetna Preferred Provider Organization* does have agreements with some *hospitals* where *medical necessity* reviews may be waived or where pre-certification requirements differ from this *Plan*.

The *Aetna Preferred Provider Organization* is the "named fiduciary" for purposes of an appeal of a Pre-Service claim, as described in U.S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), for any claim for which Aetna performs *health care management* services.

## NONPREFERRED PROVIDERS

A *nonpreferred provider* does not have an agreement in effect with the *Aetna Preferred Provider Organization*. This *Plan* will allow only the *customary and reasonable amount* as a *covered expense*. The *Plan* will pay its percentage of the *customary and reasonable amount* for the *nonpreferred provider* services, supplies and treatment. The *covered person* is responsible for the remaining balance. This results in greater out-of-pocket expenses to the *covered person*.

## REFERRALS

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

## EXCEPTIONS

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

1. *Emergency services* by a *nonpreferred provider* in the emergency department of a *hospital*. If the *covered person* is admitted to the *hospital* on an *emergency basis*, *covered expenses* shall be payable at the *preferred provider* level. The in-network benefit will continue for the duration of the hospitalization if *emergency admission* is required (e.g., heart attack, serious accident).
2. *Nonpreferred anesthesiologist* when the operating surgeon is an *Aetna Preferred Provider* and/or the facility where such services are rendered is an *Aetna Preferred Provider*.
3. *Nonpreferred assistant surgeon* if the operating surgeon is an *Aetna Preferred Provider*.

4. Radiologist or pathologist services for interpretation of x-rays and diagnostic laboratory and surgical pathology tests rendered by a *nonpreferred provider* when the *facility* where such services are rendered is an *Aetna Preferred Provider*.
5. Diagnostic laboratory and surgical pathology tests referred to a *nonpreferred provider* by an *Aetna Preferred Provider*.
6. While the *covered person* is confined to an *Aetna Preferred Provider hospital*, the *Aetna Preferred Provider physician* requests a consultation from a *nonpreferred provider* or a newborn visit is performed by a *nonpreferred provider*.
7. *Medically necessary* specialty services, supplies or treatments which are not available from a provider within the *Aetna Preferred Provider Organization*.
8. *Covered expenses* when a *covered person* does not have access to *Aetna Preferred Providers* within thirty-five (35) miles of his or her place of residence.
9. Treatment rendered at a facility of the uniformed services or Indian Health Care facility.

## MEDICAL EXPENSE BENEFIT

This section describes the *covered expenses* of the *Plan*. All *covered expenses* are subject to applicable *Plan* provisions including, but not limited to: deductible, *copay*, *coinsurance* and *maximum benefit* provisions as shown on the *Schedule of Benefits*, unless otherwise indicated. Any portion of an expense *incurred* by the *covered person* for services, supplies or treatment, that is greater than the *customary and reasonable amount* for *nonpreferred providers* or *negotiated rate* for *preferred providers* will not be considered a *covered expense* by this *Plan*. Specified preventive care expenses will be considered to be *covered expenses*.

### COPAY

The *copay* is the amount payable by the *covered person* for certain services, supplies or treatment rendered by a *preferred provider*. The service and applicable *copay* are shown on the *Schedule of Benefits*. The *copay* must be paid each time a treatment or service is rendered.

The *copay* will not be applied toward the following:

1. The calendar year deductible.
2. The maximum out-of-pocket expense limit.

### DEDUCTIBLES

#### Individual Deductible

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

#### Family Deductible

When two (2) covered members of the same family have each met their individual deductible amount during a calendar year, the family deductible amount shall be considered satisfied for that calendar year and no further deductible amount shall be taken from the expenses of any covered family member for the remainder of that calendar year.

### COINSURANCE

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

### OUT-OF-POCKET EXPENSE LIMIT

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

After two (2) covered family members have each incurred an amount equal to the individual out-of-pocket expense limit listed on the *Schedule of Benefits*, the *Plan* will pay one hundred percent (100%) of *covered expenses* for all covered family members for the remainder of the calendar year.

### *Out-of-Pocket Expense Limit Exclusions*

The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit and will not be payable at one hundred percent (100%), even if the out-of-pocket expense limit has been satisfied:

1. Expenses for services, supplies and treatments not covered by this *Plan*, to include charges in excess of the *customary and reasonable amount or negotiated rate*, as applicable.
2. Deductible(s).
3. *Copays*.
4. Expenses incurred as a result of failure to obtain pre-certification.

### *MAXIMUM BENEFIT*

The *Schedule of Benefits* may contain separate *maximum benefit* limitations for specified conditions and/or services.

### *HOSPITAL/AMBULATORY SURGICAL FACILITY/FREESTANDING SURGICENTER*

*Inpatient hospital* admissions are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits as specified in the *Medical/Dental Claim Filing Procedure* section of this document.

*Covered expenses* shall include:

1. *Room and board* for treatment in a *hospital*, including *intensive care units*, cardiac care units and similar *medically necessary* accommodations. *Covered expenses for room and board* shall be limited to the *hospital's semiprivate rate*. *Covered expenses for intensive care or cardiac care units* shall be the *customary and reasonable amount for nonpreferred providers* and the percentage of the *negotiated rate for preferred providers*. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the *covered person*.
2. Miscellaneous *hospital* services, supplies, and treatments including, but not limited to:
  - a. Admission fees, and other fees assessed by the *hospital* for rendering 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* or *freestanding surgicenter*, including follow-up care provided within seventy-two (72) hours of a procedure.
4. Charges for pre-admission testing (x-rays and lab tests).

### *FACILITY PROVIDERS*

Services provided by a *facility* provider are covered if such services would have been covered if performed in a *hospital, ambulatory surgical facility or freestanding surgicenter*.

## **AMBULANCE SERVICES**

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

*Covered expenses* shall include:

1. Ambulance services for air or ground transportation for the *covered person* from the place of *injury* or serious medical incident to the nearest *hospital* where treatment can be given.
2. Ambulance service is covered in a non-emergency situation only to transport the *covered person* to or from a *hospital* or between *hospitals* for required treatment when such transportation 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.

If the *covered person* is admitted to a *nonpreferred hospital* after *emergency* treatment, ambulance service is covered to transport the *covered person* from the *nonpreferred hospital* to a *preferred hospital* after the patient's condition has been stabilized, provided such transport is certified by the attending *physician* as *medically necessary*.

## **EMERGENCY ROOM SERVICES**

Coverage for emergency room treatment shall be paid in accordance with the *Schedule of Benefits* provided the condition meets the definition of *emergency* herein.

Emergency room treatment at a *preferred provider facility* for conditions that do not meet the definition of *emergency* will be considered non-emergency use of the emergency room and will be subject to the benefits as shown on the *Schedule of Benefits*. If emergency room services at a *nonpreferred provider facility* are used for treatment of a non-emergency medical condition, the *facility* and *physician* charges for such treatment shall not be considered *covered expenses*.

## **URGENT CARE CENTER**

*Covered expenses* shall include charges for treatment in an *urgent care center*, payable as specified on the *Schedule of Benefits*.

## **IN-STORE HEALTH CLINIC**

*Covered expenses* shall include *professional provider* services rendered in an *in-store health clinic*, including but not limited to basic, non-emergent medical care for acute *illnesses* and minor *injuries*, such as sore throat, cold, flu, rashes, coughs, fever, bronchitis, earaches, pink eye, headaches, poison ivy, sunburn, nausea and vomiting, diarrhea, etc.

## **PHYSICIAN SERVICES AND PROFESSIONAL PROVIDER SERVICES**

*Covered expenses* shall include the following services when performed by a *physician* or a *professional provider*:

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, *covered expenses* shall include the surgical allowance for the highest paying procedure plus fifty percent (50%) of the surgical allowance for the second highest paying procedure and twenty-five percent (25%) of the surgical allowance for each additional procedure.

When two (2) or more unrelated operations or procedures are performed at the same operative session, *covered expenses* shall include the surgical allowance for each procedure.

3. Surgical assistance provided by a *physician* or *professional provider* if it is determined that the condition of the *covered person* or the type of surgical procedure requires such assistance. *Covered expenses* for the services of an assistant surgeon are limited to twenty percent (20%) of the surgical allowance.
4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office.
5. Consultations requested by the attending *physician* during a *hospital confinement*. Consultations do not include staff consultations that are required by a *hospital's* rules and regulations.
6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.
7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.
8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

### *SECOND SURGICAL OPINION*

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

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

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

### *DIAGNOSTIC SERVICES AND SUPPLIES*

*Covered expenses* shall include services and supplies for diagnostic laboratory tests, electronic tests, pathology, ultrasound, nuclear medicine, magnetic imaging and x-rays.

### *TRANSPLANT*

Transplant procedures are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits for the *hospital confinement* as specified in the *Medical/Dental Claim Filing Procedure* section of this document.

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

1. When the recipient is covered under this *Plan*, the *Plan* will pay the recipient's *covered expenses* related to the transplant.
2. When the donor is covered under this *Plan*, the *Plan* will pay the donor's *covered expenses* related to the transplant, provided the recipient is also covered under this *Plan*. *Covered expenses incurred* by each person will be considered separately for each person.
3. Expenses *incurred* by the donor who is not ordinarily covered under this *Plan* according to eligibility requirements will be *covered expenses* to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this *Plan*. The donor's expense will be payable up to a maximum of \$5,000.

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 expense* under this *Plan*.

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

#### *Institutes of Excellence Program*

In addition to the above transplant benefits, the *covered person* may be eligible to participate in an Institutes of Excellence Program. *Covered persons* should contact the *Health Care Management Organization* to discuss this benefit by calling:

1-866-893-4472

An Institute of Excellence is a *facility* within an Institutes of Excellence Network that has been chosen for its proficiency in performing one or more transplant procedures. Usually located throughout the United States, the Institutes of Excellence *facilities* have greater transplant volumes and surgical team experience than other similar *facilities*.

Transplant procedures are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits for the *hospital confinement* as specified in the *Medical/Dental Claim Filing Procedure* section of this document.

#### *PREGNANCY*

*Covered expenses* shall include services, supplies and treatment related to *pregnancy* or *complications of pregnancy* for a covered female *employee*, a covered female spouse of a covered *employee*, and *dependent* female 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* for a covered female *employee* or a covered female spouse of a covered *employee*.

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

#### *BIRTHING CENTER*

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

#### *STERILIZATION*

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

#### *INFERTILITY SERVICES*

*Covered expenses* shall include expenses for infertility testing for *employees* and their covered spouse.

*Covered expenses* for infertility testing are limited to the actual testing for a diagnosis of infertility. Any outside intervention procedures (e.g., artificial insemination) will not be considered a *covered expense*.

## **CONTRACEPTIVES**

*Covered expenses* shall include charges for medical procedures or supplies related to contraception, including contraceptive devices, contraceptive injections and the surgical implantation and removal of contraceptive devices.

Charges for other contraceptives, including oral contraceptives (birth control pills), injectable contraceptives (Depo-Provera), transdermal contraceptives and contraceptive vaginal rings shall be covered under the *Prescription Drug Program* only.

## **WELL NEWBORN CARE**

The *Plan* shall cover well newborn care as part of the mother's claim.

Such care shall include, but is not limited to:

1. *Physician* services
2. *Hospital* services
3. Circumcision

## **ROUTINE PREVENTIVE CARE**

Routine Preventive Care shall include:

1. Evidence-based supplies 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. Routine mammograms for women.
3. Colonoscopies.
4. Routine immunizations, as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention for infants and children through age six (6); children and adolescents aged seven (7) through eighteen (18) years and adults aged nineteen (19) years and older.
5. Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration for infants, children, adolescents and adult women, unless included in the USPSTF recommendations.

The *Plan* will apply reasonable medical management techniques to determine the appropriate frequency, method, treatment, or setting for a preventive item or service to the extent that such techniques are not specified in the recommendations or guidelines.

Routine preventive care is subject to the *maximum benefit* as specified on the *Schedule of Benefits*.

## **ROUTINE VISION EXAM AND VISION HARDWARE**

Routine vision exam and vision hardware are subject to the *maximum benefit* as specified on the *Schedule of Benefits*.

## **ROUTINE HEARING EXAM AND HEARING AIDS**

Routine hearing exam and hearing aids are subject to the *maximum benefit* as specified on the *Schedule of Benefits*.

## **THERAPY SERVICES**

Therapy services must be ordered by a *physician* to aid restoration of normal function lost due to *illness* or *injury*.

*Covered expenses* shall include:

1. Services of a *professional provider* for physical therapy, occupational therapy, speech therapy or respiratory therapy.
2. Radiation therapy and chemotherapy.
3. Dialysis therapy or treatment.
4. Vision therapy (orthoptics).
5. Cognitive therapy.

*Outpatient* therapy services are subject to the *maximum benefit* specified on the *Schedule of Benefits*.

## **EXTENDED CARE FACILITY**

*Extended care facility confinement* is subject to pre-certification. Failure to obtain pre-certification shall result in a reduction of benefits as specified in the *Medical/Dental Claim Filing Procedure* section of this document.

*Extended care facility* services, supplies and treatments shall be a *covered expense* provided the *covered person* is under a *physician's* continuous care and the *physician* certifies that the *covered person* must have twenty-four (24) hours-per-day nursing care.

*Covered expenses* shall include:

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

## **HOME HEALTH CARE**

*Home health care* is subject to pre-certification. Failure to obtain pre-certification shall result in a reduction of benefits as specified in the *Medical/Dental Claim Filing Procedure* section of this document.

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

1. Part-time or intermittent nursing care by a *nurse*;
2. Physical, respiratory, occupational or speech therapy;
3. Part-time or intermittent *home health aide services* for a *covered person* who is receiving covered nursing or therapy services;

No *home health care* benefits will be provided for dietitian services (except as may be specifically provided herein), homemaker services, maintenance therapy, dialysis treatment, food or home delivered meals, rental or purchase of *durable medical equipment* or prescription or non-prescription drugs or biologicals.

## *HOSPICE CARE*

*Hospice* care is subject to pre-certification. Failure to obtain pre-certification shall result in a reduction of benefits as specified in the *Medical/Dental Claim Filing Procedure* section of this document.

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

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

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

*Covered expenses* shall include:

1. *Confinement* in a *hospice* to include ancillary charges and *room and board*.
2. Services, supplies and treatment provided by a *hospice* to a *covered person* in a home setting.
3. *Physician* services and/or nursing care by a *nurse*.
4. Physical therapy, occupational therapy, speech therapy or respiratory therapy.
5. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be *medically necessary*.
6. Counseling services provided through the *hospice*.
7. Bereavement counseling as a supportive service to *covered persons* in the terminally ill *covered person's* immediate family, including by a licensed pastoral counselor. 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 *covered person* within six (6) months of the terminally ill person's death and shall be limited to a maximum of fifteen (15) visits.

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

## *DURABLE MEDICAL EQUIPMENT*

Rental or purchase, whichever is less costly, of *medically necessary durable medical equipment* which is prescribed by a *physician* and required for therapeutic use by the *covered person* shall be a *covered expense*. A charge for the purchase or rental of *durable medical equipment* is considered *incurred* on the date the equipment is received/delivered. *Durable medical equipment* that is received/delivered after the termination date of a *covered person's* coverage under this *Plan* is not covered. Repair or replacement of purchased *durable medical equipment* which is *medically necessary* due to normal use or a physiological change in the patient's condition will be considered a *covered expense*.

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

## *PROSTHESES*

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

## *ORTHOTICS*

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a *covered expense*.

Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered. Replacement will be covered only if *medically necessary* due to normal use or a physiological change in the patient's condition necessitates earlier replacement.

## *DENTAL SERVICES*

Surgical extraction of erupted teeth and of soft tissue, partially bony, and completely bony impacted teeth shall be considered a *covered expense*.

*Facility* charges for oral surgery or dental treatment that ordinarily could be performed in the provider's office will be covered only if the *covered person* has a concurrent hazardous medical condition that prohibits performing the treatment safely in an office setting.

## *ORTHOGNATHIC DISORDERS*

Surgical and nonsurgical treatment of orthognathic disorders shall be a *covered expense*, but shall not include orthodontia.

## *SPECIAL EQUIPMENT AND SUPPLIES*

*Covered expenses* shall include *medically necessary* special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof; 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; a wig or hairpiece when required due to chemotherapy, radiation therapy or surgery; surgical dressings and other medical supplies ordered by a *professional provider* in connection with medical treatment, but not common first aid supplies.

## *COSMETIC/RECONSTRUCTIVE SURGERY*

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

1. A *covered person* receives an *injury* as a result of an *accident* and as a result requires surgery. *Cosmetic* or *reconstructive surgery* and treatment must be for the purpose of restoring the *covered person* to his normal function immediately prior to the *accident*.
2. It is required to correct a congenital anomaly, for example, a birth defect.

## ***MASTECTOMY (WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998)***

This *Plan* intends to comply with the provisions of the federal law known as the Women's Health and Cancer Rights Act of 1998.

*Covered expenses* will include eligible charges related to *medically necessary* mastectomy.

For a *covered person* who elects breast reconstruction in connection with such mastectomy, *covered expenses* will include:

1. reconstruction of a surgically removed breast; and
2. surgery and reconstruction of the other breast to produce a symmetrical appearance.

Prostheses (and *medically necessary* replacements) and physical complications from all stages of mastectomy, including lymphedemas will also be considered *covered expenses* following all *medically necessary* mastectomies.

## ***MENTAL & NERVOUS DISORDERS AND CHEMICAL DEPENDENCY CARE***

### ***Inpatient or Partial Confinement***

Subject to the pre-certification provisions of the *Plan*, the *Plan* will pay the applicable *coinsurance*, as shown on the *Schedule of Benefits*, for *confinement* or *partial confinement* in a *hospital* or *treatment center* for treatment, services and supplies related to the treatment of *mental and nervous disorders* and *chemical dependency*.

*Covered expenses* shall include:

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

### ***Outpatient***

The *Plan* will pay the applicable *coinsurance*, as shown on the *Schedule of Benefits*, for *outpatient* treatment, services and supplies related to the treatment of *mental and nervous disorders* and *chemical dependency*.

## ***PRESCRIPTION DRUGS***

Prescription drugs dispensed in a provider's office shall be considered a *covered expense* under this *Medical Expense Benefit*.

The application of *copays* under the *Prescription Drug Program* shall not be considered a *covered expense* under the *Medical Expense Benefit*.

## ***PODIATRY SERVICES***

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

### *PRIVATE DUTY NURSING*

*Medically necessary services of a private duty nurse only shall be a covered expense.*

Coverage for *medically necessary* private duty nursing shall be subject to the *maximum benefit* specified on the *Schedule of Benefits*.

### *CHIROPRACTIC CARE*

*Covered expenses* include initial consultation, x-rays and treatment (including maintenance care), subject to the *maximum benefit* shown on the *Schedule of Benefits*.

### *PATIENT EDUCATION*

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

### *OUTPATIENT CARDIAC/PULMONARY REHABILITATION PROGRAMS*

*Covered expenses* shall include charges for qualified *medically necessary outpatient* cardiac/pulmonary rehabilitation programs.

### *SURCHARGES*

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

## MEDICAL EXCLUSIONS

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

1. Charges for *pre-existing conditions* as specified in *Pre-Existing Conditions* and *Certificates of Coverage*.
2. Charges for services, supplies or treatment for the reversal of surgical sterilization procedures.
3. Charges for services, supplies or treatment related to the treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate mother, embryo implantation, or gamete intrafallopian transfer (GIFT).
4. 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. However, treatment of congenital hermaphroditism is a *covered expense*.
5. Charges for treatment or surgery for sexual dysfunction or inadequacies unless related to *injury* or organic *illness*.
6. Charges for *hospital* admission on Friday, Saturday or Sunday unless the admission is an *emergency* situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, *hospital* expenses will be payable commencing on the date of actual surgery.
7. Charges for *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*.
8. Charges for biofeedback therapy.
9. Charges for services, supplies or treatments which are primarily educational in nature, except as specified in *Medical Expense Benefit, Patient Education*; 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 marriage, career, financial or legal counseling.
11. 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.
12. Charges for routine vision examinations and eye refractions; eyeglasses or contact lenses; dispensing optician's services, except as specified herein.
13. 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.
14. 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.
15. 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.

16. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.
17. Charges for *outpatient* prescription drugs, except as specifically indicated in *Medical Expense Benefit, Prescription Drugs*.
18. Charges for the Prescription Drug *copay* applicable to the *Prescription Drug Program*.
19. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts.
20. Expenses for a *cosmetic surgery* or procedure and all related services, except as specifically stated in *Medical Expense Benefit, Cosmetic/Reconstructive Surgery*.
21. Charges *incurred* as a result of, or in connection with, any procedure or treatment excluded by this *Plan* which has resulted in medical complications, except for complications from a non-covered abortion as specified herein.
22. Charges for services provided to a *covered person* for an elective abortion (See *Medical Expense Benefit, Pregnancy* for specifics regarding the coverage of abortions). However, complications from such procedure shall be a *covered expense* for a covered female *employee* or the covered female spouse of an *employee*.
23. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and *hospital confinements* for weight reduction programs, except as specifically provided herein.
24. Charges for surgical weight reduction procedures and all related charges, unless resulting from *morbid obesity*.
25. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid, except as specifically provided herein.
26. Charges related to acupuncture treatment.
27. Charges for methods of treatment to alter vertical dimension.
28. Charges for treatment of temporomandibular joint dysfunction (TMJ) and related conditions by any method.
29. Charges for *custodial care*, domiciliary care or rest cures.
30. Charges for travel or accommodations, whether or not recommended by a *physician*, except as specifically provided herein.
31. Charges for wigs, artificial hairpieces, artificial hair transplants, or any drug - prescription or otherwise - used to eliminate baldness or stimulate hair growth, except as specified herein.
32. Charges for expenses related to hypnosis.
33. Charges for the expenses of the donor of an organ or tissue for transplant to a recipient who is not a *covered person* under this *Plan*.
34. Charges for professional services billed by a *professional provider* 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.

35. Charges for environmental change including *hospital* or *physician* charges connected with prescribing an environmental change.
36. Charges for *room and board* in a *facility* for days on which the *covered person* is permitted to leave (a weekend pass, for example).
37. Charges for chelation therapy, except as treatment of heavy metal poisoning.
38. Charges for massage therapy unless prescribed by a chiropractor, podiatrist or *physician*, sex therapy, diversional therapy or recreational therapy.
39. Charges for procurement and storage of one's own blood, unless *incurred* within three (3) months prior to a scheduled surgery.
40. Charges for holistic medicines or providers of naturopathy.
41. Charges for or related to the following types of treatment:
  - a. primal therapy;
  - b. rolfing;
  - c. psychodrama;
  - d. megavitamin therapy;
  - e. visual perceptual training.
42. Charges for structural changes to a house or vehicle.
43. Charges for exercise programs for treatment of any condition, except as specified herein.
44. Charges by a Christian Science practitioner.
45. Charges for immunizations required for travel.
46. Charges for any services, supplies or treatment not specifically provided herein.

# PRESCRIPTION DRUG PROGRAM

## *PHARMACY OPTION*

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

## *PHARMACY OPTION COPAY*

The *copay* is applied to each covered pharmacy drug charge and is shown on the *Schedule of Benefits*. The *copay* amount is not a *covered expense* under the *Medical Expense Benefit*. Any one prescription is limited to the greater of a thirty-four (34) day supply or a one hundred (100) units.

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

## *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 which may be prescribed for heart disease, high blood pressure, asthma, etc.).

## *MAIL ORDER OPTION COPAY*

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

## *COVERED PRESCRIPTION DRUGS*

1. Drugs prescribed by a *physician* that require a prescription either by federal or state law, including injectables and insulin, except drugs excluded by the *Plan*.
2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.
3. Insulin, insulin needles and syringes, diabetic supplies and blood glucose monitoring units.
4. Oral contraceptives, injectable contraceptives, transdermal contraceptives and contraceptive vaginal rings.
5. Drugs used in the treatment of erectile dysfunction (limited to 15 pills per month).
6. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a *qualified prescriber*.
7. Chantix.

## *LIMITS TO THIS BENEFIT*

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

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

## *EXPENSES NOT COVERED*

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin.
2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.
3. Immunization agents or biological sera, blood or blood plasma.
4. A drug or medicine labeled: "Caution - limited by federal law to *investigational* use."
5. *Experimental* drugs and medicines, even though a charge is made to the *covered person*.
6. Any charge for the administration of a covered prescription drug.
7. Any drug or medicine that is consumed or administered at the place where it is dispensed.
8. A drug or medicine that is to be taken by the *covered person*, in whole or in part, while *hospital* confined. This includes being confined in any institution that has a *facility* for dispensing drugs.
9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.
10. A charge for hypodermic syringes and/or needles (other than insulin).
11. A charge for infertility medication.
12. A charge for contraceptive devices.
13. A charge for medications that are cosmetic in nature (*i.e.*, treating hair loss, wrinkles, etc.).
14. A charge for growth hormones.
15. A charge for weight loss drugs.
16. A charge for Tretinoins, all dosage forms, Differin and Tazorac for *covered persons* age twenty-six (26) and over.
17. A charge for prescription drugs for smoking cessation purposes, including smoking deterrent patches, other than as specifically listed herein.
18. A charge for non-legend drugs, other than as specifically listed herein.

## *SPECIALTY PHARMACY PROGRAM*

The Specialty Pharmacy Program is available for select specialty drugs including select injectable and oral medications for the following conditions.

Allergic Asthma

Crohn's disease

Enzyme replacement for Lysosomal Storage Disorder

Gaucher disease

Hematopoietics

Hemophilia, Von Willebrand disease and related bleeding disorders

Hepatitis C

Hormonal therapies

Immune deficiencies  
Multiple Sclerosis  
Oncology  
Osteoarthritis  
Psoriasis  
Pulmonary Arterial Hypertension  
Pulmonary disease  
Renal disease  
Respiratory Syncytial Virus  
Rheumatoid Arthritis  
Other Disorders

To take advantage of this program, the *covered person* will need to transfer the related prescription to Caremark. To transfer a prescription, call 1-800-237-2767. A representative of Caremark will call the *covered person's physician* and take care of the appropriate paperwork.

The medication will be shipped to a location of the *covered person's* choice from a Caremark specialty pharmacy.

#### *NOTICE OF AUTHORIZED REPRESENTATIVE*

The *covered person* may provide the *plan administrator* (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a *covered person* and consent to release of information related to the *covered person* to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

#### *APPEALING A DENIED POST-SERVICE PRESCRIPTION DRUG CLAIM*

The "*named fiduciary*" for purposes of an appeal of a denied Post-Service Prescription Drug Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the *claims processor*.

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

The following describes the review process and rights of the *covered person*:

1. The *covered person* has the right to submit documents, information and comments and to present evidence and testimony.
2. The *covered person* has the right to access, free of charge, *relevant information* to the claim for benefits.
3. Before a final determination on appeal is rendered, the *covered person* will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the *Plan* in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the *covered person* a reasonable opportunity to respond prior to that date.
4. The review takes into account all information submitted by the *covered person*, even if it was not considered in the initial benefit determination.
5. The review by the *named fiduciary* will not afford deference to the original denial.
6. The *named fiduciary* will not be:
  - a. The individual who originally denied the claim, nor
  - b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:

- a. The *named fiduciary* will consult with a *professional provider* who has appropriate training and experience in the field involving the medical judgment; and
  - b. The *professional provider* utilized by the *named fiduciary* will be neither:
    - (i.) An individual who was consulted in connection with the original denial of the claim, nor
    - (ii.) A subordinate of any other *professional provider* who was consulted in connection with the original denial.
8. If requested, the *named fiduciary* will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

### ***NOTICE OF BENEFIT DETERMINATION ON A POST-SERVICE PRESCRIPTION DRUG CLAIM APPEAL***

The *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.
2. Reference to specific *Plan* provisions on which the denial is based.
3. A statement that the *covered person* has the right to access, free of charge, *relevant information* to the claim for benefits.
4. A statement of the *covered person's* right to request an external review and a description of the process for requesting such a review.
5. A statement that if the *covered person's* appeal is denied, the *covered person* has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
  - a. A copy of that criterion, or
  - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the denial was based on *medical necessity, experimental/investigational* treatment or similar exclusion or limit, the *plan administrator* (or its designee) will supply either:
  - a. An explanation of the scientific or clinical judgment, applying the terms of the *Plan* to the claimant's medical circumstances, or
  - b. A statement that such explanation will be supplied free of charge, upon request.

### ***EXTERNAL APPEAL***

A *covered person*, or the *covered person's* authorized representative, may request a review of a denied claim by making written request to the *named fiduciary* within four (4) months of receipt of notification of the final internal denial of benefits. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. {Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1<sup>st</sup> falls on a Saturday, Sunday or Federal holiday.} The *Plan* may charge a filing fee to the *covered person* requesting an external review, subject to applicable laws and regulations.

### ***RIGHT TO EXTERNAL APPEAL***

Within five (5) business days of receipt of the request, the *claims processor* will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that:

1. The *covered person* incurring the claim is or was covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the *Plan* at the time the health care item or service was provided;
2. The final internal denial does not relate to the *covered person's* failure to meet *Plan* eligibility requirements as stated in the section, *Eligibility, Enrollment and Effective Date*;
3. The *covered person* has exhausted the *Plan's* appeal process, to the extent required by law; and
4. The *covered person* has provided all of the information and forms required to complete an external review.

## ***NOTICE OF RIGHT TO EXTERNAL APPEAL***

The *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 866-444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the *covered person* to perfect the external review request by the later of the following:
  - a. The four (4) month filing period; or
  - b. Within the forty-eight (48) hour time period following the *covered person's* receipt of notification.

## ***INDEPENDENT REVIEW ORGANIZATION***

An Independent Review Organization (IRO) that is accredited by URAC or a similar nationally recognized accrediting organization shall be assigned to conduct the external review. The assigned IRO will timely notify the *covered person* in writing of the request's eligibility and acceptance for external review.

## ***NOTICE OF EXTERNAL REVIEW DETERMINATION***

The assigned IRO shall provide the *plan administrator* (or its designee) and the *covered person* (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the *covered person*, the *Plan* and *claims processor*, except to the extent that other remedies may be available under State or Federal law.

## ***EXPEDITED EXTERNAL REVIEW***

The *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) the right to request an expedited external review upon the *covered person's* receipt of either of the following:

1. A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the *covered person* or the *covered person's* ability to regain maximum function and the *covered person* has filed an internal appeal request.
2. A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the *covered person* or the *covered person's* ability to regain maximum function or if the final determination involves any of the following:
  - a. An admission,
  - b. Availability of care,
  - c. Continued stay, or
  - d. A health care item or service for which the *covered person* received *emergency services*, but has not been discharged from a *facility*.

Immediately upon receipt of the request for *Expedited External Review*, the *Plan* will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the section, *Right to External Appeal*.
2. Send notice of the *Plan's* decision, as described in the section, *Notice of Right to External Appeal*.

Upon determination that a request is eligible for external review, the *Plan* will do all of the following:

1. Assign an IRO as described in the section, *Independent Review Organization*.

2. Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the *covered person's* medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, *Notice of External Review Determination*. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the *plan administrator* (or its designee) and the *covered person* (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

## DENTAL EXPENSE BENEFIT

Subject to all the terms of the *Plan*, the *Plan* will pay a dental benefit for covered dental expenses. The dental benefit is a percentage of the *customary and reasonable amount* for covered dental expenses, as shown on the *Schedule of Benefits*.

### COINSURANCE

The *Plan* pays a specified percentage of the *customary and reasonable amount* for *covered expenses*. That percentage is listed on the *Schedule of Benefits*. The *covered person* is responsible for the difference.

### MAXIMUM BENEFIT

The maximum calendar year benefit payable on behalf of a *covered person* for covered dental expense is stated on the *Schedule of Benefits*. If the *covered person's* coverage under the *Plan* terminates and he subsequently returns to coverage under the *Plan* during the calendar year, the *maximum benefit* will be calculated on the sum of benefits paid by the *Plan*.

The *maximum benefit* for orthodontic treatment while a *covered person* is covered by this *Plan* is also specified on the *Schedule of Benefits*. If the *covered person* receives more than one course of orthodontic treatment while covered by this *Plan* and if it can be clearly shown that any later course of treatment is not a part of a previous course of treatment, then the *covered person* will be entitled to a separate *maximum benefit* for each course of treatment.

### ALTERNATIVE TREATMENT

In the event the *dentist* recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining, as a result of the *covered person's* choice to obtain the higher-cost treatment will be the *covered person's* responsibility.

### DENTAL INCURRED DATE

A dental procedure will be deemed to have commenced on the date the covered dental expense is *incurred*, except as follows:

1. For installation of a prosthesis other than a bridge or crown, on the date the impression was made;
2. For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;
3. For endodontic treatment, on the date the pulp chamber is opened.

There are times when one overall charge is made for all or part of a course of treatment. In this case the *claims processor* will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be *incurred* as each visit or treatment is completed.

### COVERED DENTAL EXPENSES

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

*Class I - Diagnostic and Preventive Dental Services*

1. Routine oral examination: Initial or periodic, limited to once every six (6) months.
2. Prophylaxis: Scaling and cleaning of teeth, limited to once.
3. Dental x-rays as follows:
  - a. Supplementary bite-wing x-rays, limited to once every six (6) months.
  - b. Panorex or full mouth series, limited to one (1) every thirty-six (36) months.
4. Topical application of fluoride for *dependent* children through the age of nineteen (19), limited to one (1) treatment every six (6) months.

*Class II - Basic Dental Services*

1. Space maintainers.
2. Topical application of sealant to permanent posterior teeth.
3. *Emergency* palliative treatment primarily for relief of dental pain, not cure. Only paid as a separate benefit when no other treatment (except x-rays) is rendered during the visit.
4. Sedative fillings, covered as a separate procedure only if no other service (except x-rays) is rendered during the visit.
5. Restorations (fillings) to restore teeth to normal function, using amalgam, silicate, acrylic, synthetic, and composite filling materials to restore teeth broken down by decay or *injury*.
6. Pin retention when part of the restoration instead of gold or crown retention.
7. Endodontics as follows:
  - a. Direct pulp capping.
  - b. Pulpotomy.
  - c. Root canal therapy.
  - d. Apicoectomy.
  - e. Hemisection.
  - f. Retrograde fillings.
8. Oral surgery, including customary postoperative treatment furnished in connection with oral surgery, as follows:
  - a. Simple extraction of one (1) or more teeth.
  - b. Extraction of tooth root.
  - d. Incision and drainage of a tumor or a cyst.
  - e. Alveolectomy, alveoloplasty, and frenectomy.
  - f. Exostosis or hyperplastic tissue and excision of oral tissue for biopsy.
  - g. Re-implantation or transplantation of a natural tooth.
  - h. General anesthesia, only when provided in conjunction with a surgical procedure.
9. Bacteriologic cultures in connection with a covered dental service.
10. Therapeutic injections of antibiotics administered by a *dentist*.
11. Relining of present dentures.
12. Rebasing of present dentures.

*Class III - Major Dental Services*

1. Periodontics as follows:
  - a. Gingivectomy/gingivoplasty, gingival curettage, gingival flap procedure or mucogingival surgery.
  - b. Scaling and root planing.
  - c. Pedicle and free soft tissue grafts, and vestibuloplasty.
  - d. Occlusal adjustment.
  - e. Excision of pericoronal gingiva.
  - f. Periodontal prophylaxis.
  - g. Osseous surgery.
2. Repairs and adjustments to full or partial dentures.
3. Denture adjustment, only if done more than six (6) months after the initial insertion of the denture.
4. Repair or recementing of crowns, inlays, onlays or bridgework.
5. Post and core on permanent teeth only.
6. Plastic or stainless steel crowns will be covered for primary teeth only.
7. Gold Inlays and Onlays: Covered only when the tooth cannot be restored by basic restorations. Restorations on teeth which are anterior to the first bicuspid are not covered.
8. Porcelain Restorations: Covered only when the tooth cannot be restored by basic restorations. Restorations on teeth which are posterior to the first bicuspid are not covered.
9. Crowns: Covered only when the tooth cannot be restored by basic restorations.
10. Initial installation of fixed bridge (including abutments) to replace one (1) or more natural teeth.
11. Removable bridge, partial or complete dentures to replace one (1) or more natural teeth.
12. Replacement of an existing partial or full removable denture or fixed bridge, or the addition of teeth to existing bridgework to replace extracted natural teeth.
13. Complete dentures.

*Covered expenses* for both a temporary and permanent prosthesis will be limited to the charge for the permanent prosthesis.

*Class IV - Orthodontic Services*

1. Any dental expense furnished in connection with the orthodontic treatment.
2. Active appliances, including diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.
3. Comprehensive full-banded and bracketed orthodontic treatment.

## DENTAL EXCLUSIONS

In addition to the *Plan Exclusions*, no benefit will be provided under this *Plan* for dental expenses *incurred* by a *covered person* for the following:

1. Charges for any device ordered while the individual was covered under this *Plan* and not delivered or installed until after termination of coverage.
  2. Replacement of lost, missing or stolen appliances or prosthetic devices or duplicate appliances or prosthetic devices.
  3. Charges for all services, supplies and treatment related to dental implants.
  4. Any procedure not listed under *Covered Dental Expenses*.
  5. Any procedure which began before the date the *covered person's* dental coverage started, to include a service which is:
    - a. An appliance, or modification of an appliance, for which an impression was made before such person became covered, or
    - b. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered, or
    - c. Root canal therapy, for which the pulp chamber was opened before such person became covered.
- X-rays and prophylaxis shall not be deemed to start a dental procedure.
6. Services, supplies or treatment that is cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or coverings placed on teeth except when used to return the tooth to normal form and function are considered cosmetic in nature.
  7. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, except as provided under *Orthodontic Services*.
  8. A service not furnished by a *dentist*, except:
    - a. Services performed by a licensed dental hygienist under a *dentist's* supervision;
    - b. X-rays ordered by a *dentist*; and
    - c. Denturist.
  9. Charges for over-dentures, including related root canal therapy and supportive restorations.
  10. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.
  11. Charges resulting from changing from one *dentist* to another while receiving treatment, or resulting from receiving care from more than one *dentist* for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one *dentist* had performed all the required dental services.
  12. Charges for precision attachments, semi-precision attachments.
  13. Charges for instruction in dental plaque control, dental hygienics, or nutritional counseling.

## PLAN EXCLUSIONS

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

1. Charges for services, supplies or treatment from any *hospital* owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.
2. Charges for an *injury* sustained or *illness* contracted while on active duty in military service, unless payment is legally required.
3. Charges for services, treatment or supplies for treatment of *illness* or *injury* which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.
4. Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the *covered person* fails to claim rights to such benefits or fails to enroll or purchase such coverage.
5. Charges in connection with any *illness* or *injury* arising out of or in the course of any employment intended for wage or profit, including self-employment.
6. Charges made for services, supplies and treatment which are not *medically necessary* for the treatment of *illness* or *injury*, or which are not recommended and approved by the attending *physician*, except as specifically stated herein, or to the extent that the charges exceed *customary and reasonable amount* or exceed the *negotiated rate*, as applicable.
7. Charges in connection with any *illness* or *injury* of the *covered person* resulting from or occurring during commission or attempted commission of a criminal battery or felony by the *covered person*.
8. To the extent that payment under this *Plan* is prohibited by any law of any jurisdiction in which the *covered person* resides at the time the expense is *incurred*.
9. Charges for services rendered and/or supplies received prior to the *effective date* or after the termination date of a person's coverage.
10. Any services, supplies or treatment for which the *covered person* is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
11. Charges for services, supplies or treatment that are considered *experimental/investigational*.
12. Charges *incurred* outside the United States if the *covered person* traveled to such a location for the sole purpose of obtaining services, supplies or treatment.
13. Charges for services, supplies or treatment rendered by any individual who is a *close relative* of the *covered person* or who resides in the same household as the *covered person*.

14. Charges for services, supplies or treatment rendered by *physicians* or *professional providers* beyond the scope of their license; for any treatment, *confinement* or service which is not recommended by or performed by an appropriate *professional provider*.
15. Charges for *illnesses* or *injuries* suffered by a *covered person* due to the action or inaction of any party if the *covered person* fails to provide information as specified in the section, *Subrogation/Reimbursement*.
16. Claims not submitted within the *Plan's* filing limit deadlines as specified in the section, *Medical/Dental Claim Filing Procedure*.
17. Charges for telephone or e-mail consultations, completion of claim forms, charges associated with missed appointments.
18. If the primary plan provides coverage through the services of an HMO and the *covered person* chooses not to use the HMO, this *Plan* will not pay for any charges disallowed by the primary plan due to failure to utilize the HMO.
19. This *Plan* will not pay for any charge which has been refused by another plan covering the *covered person* as a penalty assessed due to non-compliance with that plan's rules and regulations.
20. Charges for expenses in connection with an *injury* arising out of or relating to an accident involving the maintenance or use of a motor vehicle (other than a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle, motorized pedal cycle or like type vehicle). This exclusion shall apply to those expenses up to the minimum amount required by law in the state of residence for any *injury* arising out of an accident of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance. However, this exclusion does not apply to a *covered person* who is a non-driver when involved in an uninsured motor vehicle accident.

For purpose of this exclusion, a non-driver is defined as a *covered person* who does not have the obligation to obtain automobile insurance because he/she does not have a driver's license or because he/she is not responsible for a motor vehicle.

# ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

This section identifies the *Plan's* requirements for a person to participate in the *Plan*.

## EMPLOYEE ELIGIBILITY

All *full-time employees* regularly scheduled to work at least thirty-five (35) hours per work week and all *part-time employees* regularly scheduled to work at least twenty-six (26) hours per work week shall be eligible to enroll for coverage under this *Plan*. This does not include temporary or seasonal employees and provisional employees who do not have permanent title rights in a different title.

Retired *employees* may continue coverage by paying the applicable contribution for *employee* and/or *dependent* coverage. The *employer* reserves the right to modify *retiree* coverage subject to applicable municipal ordinances and collective bargaining agreements.

## EMPLOYEE ENROLLMENT

An *employee* must file a written application (or electronic, if applicable) with the *employer* for coverage hereunder for himself within thirty-one (31) days of becoming eligible for coverage. The *employee* shall have the responsibility of timely forwarding to the *employer* all applications for enrollment hereunder.

## EMPLOYEE(S) EFFECTIVE DATE

Eligible *employees*, as described in *Employee Eligibility*, are covered under the *Plan* on the first day of the month following completion of ninety (90) days of continuous employment, provided the *employee* has enrolled for coverage as described in *Employee Enrollment*.

Eligible *employees*, as described in *Employee Eligibility*, are covered under the *Plan* on the first day of the month following the date of hire for non-probationary employees, provided the *employee* has enrolled for coverage as described in *Employee Enrollment*.

## DEPENDENT(S) ELIGIBILITY

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

1. The term "spouse" means the spouse of the *employee* under a legally valid existing marriage with a person of the opposite sex who resides with the *employee* except as set forth below:
  - a. The term "spouse" excludes any person who is divorced from the *employee*.
  - b. The term "spouse" excludes the spouse of the *employee* who is legally separated from the *employee* when an action for divorce is filed and pending unless a court of competent jurisdiction orders the continued maintenance of the Plan benefits until such time as the judgment of divorce is entered by the court.
  - c. The term "spouse" excludes the spouse of the *employee* when the spouse does not reside with the *employee*. This exclusion includes, but is not limited to, a spouse who does not reside with the *employee* because of the spouse's separation from the *employee*.
  - d. The term "spouse" excludes the spouse of the *employee* when the spouse is covered as a Member of the Plan.
2. The term "child" means the *employee's* natural child, stepchild, legally adopted child and a child *placed for adoption*, provided the child is less than twenty-six (26) years of age.
3. An eligible child shall also include any other child of an *employee* or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has

been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this *Plan*, even if the child is not residing in the *employee's* household. Such child shall be referred to as an *alternate recipient*. *Alternate recipients* are eligible for coverage only if the *employee* is also covered under this *Plan*. 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 QMCSO, as defined in Section 609 of ERISA, or a NMSN, as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

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

4. A *dependent* child who was covered under the *Plan* prior to reaching the maximum age limit of twenty-six (26) years and who lives with the *employee*, is unmarried, incapable of self-sustaining employment and dependent upon the *employee* for support due to a mental and/or physical disability, will remain eligible for coverage under this *Plan* beyond the date coverage would otherwise terminate.

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

- a. Cessation of the mental and/or physical disability;
- b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible *employee* may enroll eligible *dependents*. However, if both the husband and wife are *employees*, each individual may 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.

### ***DEPENDENT ENROLLMENT***

An *employee* must file a written application (or electronic, if applicable) with the *employer* for coverage hereunder for 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. However, if *dependent* coverage is already in force at the time of birth, a newborn child will be automatically added for coverage and no additional enrollment is required.

### ***DEPENDENT(S) EFFECTIVE DATE***

Eligible *dependent(s)*, as described in *Dependent(s) 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 and any required contributions are made.

1. The date the *employee's* coverage becomes effective.
2. The date the *dependent* is acquired, provided the *employee* has applied for *dependent* coverage within thirty-one (31) days of the date acquired.
3. Newborn children will be considered a *dependent* under this *Plan* for thirty-one (31) days immediately following birth. For coverage under the *Plan* for the newborn beyond that date, the *employee* must submit an application for enrollment within thirty-one (31) days of birth. However, if *dependent* coverage is already in force at the time of birth, a newborn child will be automatically added for coverage and no additional enrollment is required; the child's full name, date of birth and Social Security number should be provided to the *claim processor* when available.

4. Coverage for a newly adopted or to be adopted child shall be effective on the date the child is *placed for adoption*, provided the *employee* has applied for *dependent* coverage within thirty-one (31) days of the date the child is *placed for adoption*.

#### ***SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)***

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

1. Termination of the other coverage (including exhaustion of COBRA benefits).
2. Cessation of employer contributions toward the other coverage.
3. Legal separation or divorce.
4. Termination of other employment or reduction in number of hours of other employment.
5. Death of *dependent* or spouse.
6. Cessation of other coverage because *employee* or *dependent* no longer resides or works in the service area and no other benefit package is available to the individual.
7. Cessation of *dependent* status under other coverage and *dependent* is otherwise eligible under *employee's Plan*.
8. An incurred claim that would exceed the other coverage's maximum benefit limit. The maximum benefit limit is all-inclusive and means that no further benefits are payable under the other coverage because the specific total benefit pay out maximum has been reached under the other coverage. The right for special enrollment continues for thirty (30) days after the date the claim is denied under the other coverage.

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.

#### ***SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)***

An *employee* who is currently covered or not covered under the *Plan*, but who acquires a new *dependent* may request a special enrollment period for himself, if applicable, his newly acquired *dependent* and his spouse, if not already covered under this *Plan* and otherwise eligible for coverage.

For the purposes of this provision, the acquisition of a new *dependent* includes:

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

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

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

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

### ***SPECIAL ENROLLMENT PERIOD (CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) REAUTHORIZATION ACT OF 2009)***

This *Plan* intends to comply with the Children's Health Insurance Program Reauthorization Act of 2009.

An *employee* who is currently covered or not covered under the *Plan* may request a special enrollment period for himself, if applicable, and his *dependent*. Special enrollment periods will be granted if:

1. the individual's loss of eligibility is due to termination of coverage under a state children's health insurance program or Medicaid; or,
2. the individual is eligible for any applicable premium assistance under a state children's health insurance program or Medicaid.

The *employee* or *dependent* must request the special enrollment and enroll no later than sixty (60) days from the date of loss of other coverage or from the date the individual becomes eligible for any applicable premium assistance.

### ***OPEN ENROLLMENT***

Open enrollment is the period designated by the *employer* during which the *employee* may change benefit plans or enroll in the *Plan* if he did not do so when first eligible or does not qualify for a special enrollment period. An open enrollment will be permitted once in each calendar year.

During this open enrollment period, an *employee* and his *dependents* who are covered under this *Plan* or covered under any *employer* sponsored health plan may elect coverage or change coverage under this *Plan* for himself and his eligible *dependents*. An *employee* must make written application (or electronic, if applicable) as provided by the *employer* during the open enrollment period to change benefit plans.

The *effective date* of coverage as the result of an open enrollment period will be the following January 1<sup>st</sup>.

Except for a status change listed below, the open enrollment period is the only time an *employee* may change benefit options or modify enrollment. Status changes include:

1. Change in family status. A change in family status shall include only:
  - a. Change in *employee's* legal marital status;
  - b. Change in number of *dependents*;
  - c. Termination or commencement of employment by the *employee*, spouse or *dependent*;
  - d. Change in work schedule;
  - e. *Dependent* satisfies (or ceases to satisfy) *dependent* eligibility requirements;
  - f. Change in residence or worksite of *employee*, spouse or *dependent*.
2. Change in the cost of coverage under the *employer's* group medical plan.
3. Cessation of required contributions.
4. Taking or returning from a leave of absence under the Family and Medical Leave Act of 1993.

5. Significant change in the health coverage of the *employee* or spouse attributable to the spouse's employment.
6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act of 1996.
7. A court order, judgment or decree.
8. Entitlement to *Medicare* or Medicaid, or enrollment in a state child health insurance program (CHIP).
9. A COBRA qualifying event.

## PRE-EXISTING CONDITIONS

A *pre-existing condition* is an *illness* or *injury* which existed within three (3) months before the *covered person's enrollment date* for coverage under this *Plan*. An *illness* or *injury* is considered to have existed when the *covered person*:

1. Sought or received professional advice for that *illness* or *injury*, or
2. Received medical care or treatment for that *illness* or *injury*, or
3. Received medical supplies, drugs, or medicines for that *illness* or *injury*.

Benefits will be provided for *pre-existing conditions* after the completion of a period of twelve (12) months from the *covered person's enrollment date* for coverage under this *Plan*. The *enrollment date* shall mean the first day of any applicable service waiting period or the date of hire or, in the case of a Special Enrollment Period or Open Enrollment Period, the date the enrollment form is executed.

This *pre-existing condition* limitation shall not apply to an *employee* or *dependent* less than nineteen (19) years of age, or to *pregnancy* under any circumstances.

Pre-certification from the *Health Care Management Organization* does not constitute *Plan* liability for any *pre-existing condition* charges during this *pre-existing condition* limitation period.

The *covered person* has a right to appeal the determination of coverage for *pre-existing conditions*. Refer to the *Medical/Dental Claim Filing Procedure* section of this document.

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

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

## TERMINATION OF COVERAGE

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

### *TERMINATION OF EMPLOYEE COVERAGE*

1. The date the *employer* terminates the *Plan* and offers no other group health 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, as defined by the *employer's* personnel policies.
4. The date the *employee* becomes a full-time, active member of the armed forces of any country.
5. The date the *employee* ceases to make any required contributions.

### *TERMINATION OF DEPENDENT(S) COVERAGE*

1. The date the *employer* terminates the *Plan* and offers no other group health plan.
2. The date the *employee's* coverage terminates.
3. The last day of the month in which such person ceases to meet the eligibility requirements of the *Plan*.
4. The date the *employee* ceases to make any required contributions on the *dependent's* behalf.
5. The date the *employee's dependent* spouse 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*.

### *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 (FMLA), as amended, has the right to continue coverage under this *Plan* for up to twelve (12) weeks (twenty-six (26) weeks in certain circumstances). Contact your employer to determine whether you are eligible under FMLA.

#### *Contributions*

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

#### *Reinstatement*

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

### *Repayment Requirement*

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

### *CERTIFICATES OF COVERAGE*

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

## CONTINUATION OF COVERAGE

In order to comply with federal regulations, this *Plan* includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This continuation of coverage may be commonly referred to as "COBRA coverage" or "continuation 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 dental benefits as provided under the *Plan*.

### QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a *covered person* to lose coverage under this *Plan* or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect 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*. This event is referred to below as an "18-Month Qualifying Event."
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 and Medical Leave Act of 1993, or an earlier date on which the *employee* informs the *employer* that he or she will not be returning to work.
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 submit a completed Qualifying Event Notification form to the *plan administrator* (or its designee) within sixty (60) days of the latest of:
  - a. The date of the event;
  - b. The date on which coverage under this *Plan* is or would be lost as a result of that event; or
  - c. The date on which the *employee* or *dependent* is furnished with a copy of this Plan Document and Summary Plan Description.

A copy of the Qualifying Event Notification form is available from the *plan administrator* (or its designee). In addition, the *employee* or *dependent* may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the *plan administrator* (or its designee) will notify the *employee* or *dependent* of his rights to continuation of coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."

2. When eligibility for continuation of coverage results from any qualifying event under this *Plan* other than the ones described in Paragraph 1 above, the *employer* must notify the *plan administrator* (or its designee) not later than thirty (30) days after the date on which the *employee* or *dependent* loses coverage under the *Plan* due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the *plan administrator* (or its designee) will furnish the Election Notice to the *employee* or *dependent*.
3. In the event it is determined that an individual seeking continuation of coverage (or extension of continuation coverage) is not entitled to such coverage, the *plan administrator* (or its designee) will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame as applicable to the furnishing of the Election Notice.
4. In the event an Election Notice is furnished, the eligible *employee* or *dependent* has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was covered under the *Plan* on the day before the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the *employee* or *dependent* chooses to have continuation coverage, he must advise the *plan administrator* (or its designee) of this choice by returning to the *plan administrator* (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the *plan administrator* (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:
  - a. The date coverage under the *Plan* would otherwise end; or
  - b. The date the person receives the Election Notice from the *plan administrator* (or its designee).
5. Within forty-five (45) days after the date the person notifies the *plan administrator* (or its designee) 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 continuation coverage are to be made monthly, and are due in advance, on the first day each month.

### ***COST OF COVERAGE***

1. The *Plan* requires that *covered persons* pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the *plan administrator* (or its designee) by or before the first day of each month during the continuation period. The payment must be remitted on a timely basis in order to maintain the coverage in force.
2. For a person originally covered as an *employee* or as a spouse, the cost of coverage is the amount applicable to an *employee* if coverage is continued for himself alone. For a person originally covered as a child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an *employee*.

### ***WHEN CONTINUATION COVERAGE BEGINS***

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

### ***FAMILY MEMBERS ACQUIRED DURING CONTINUATION***

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

## EXTENSION OF CONTINUATION COVERAGE

1. In the event any of the following events occur during the period of continuation coverage resulting from an 18-Month Qualifying Event, it is possible for a *dependent's* continuation coverage to be extended:

- a. Death of the *employee*.
- b. Divorce or legal separation from the *employee*.
- c. The child's loss of *dependent* status.

Written notice of such event must be provided by submitting a completed Additional Extension Event Notification form to the *plan administrator* (or its designee) within sixty (60) days of the latest of:

- (i.) The date of that event;
- (ii.) The date on which coverage under this *Plan* would be lost as a result of that event if the first qualifying event had not occurred; or
- (iii.) The date on which the *employee* or *dependent* is furnished with a copy of this Plan Document and Summary Plan Description.

A copy of the Additional Extension Event Notification form is available from the *plan administrator* (or its designee). In addition, the *dependent* may be required to promptly provide any supporting documentation as may be reasonably required for purposes of verification. Failure to properly provide the Additional Extension Event Notification and any requested supporting documentation will result in the person forfeiting their rights to extend continuation coverage under this provision. In no event will any extension of continuation coverage extend beyond thirty-six (36) months from the later of the date of the first qualifying event or the date as of which continuation coverage began.

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 coverage may be eligible to continue coverage through an extension of continuation coverage as described above. Any other *dependent* acquired during continuation coverage is not eligible to extend continuation coverage as described above.

2. A person who loses coverage on account of an 18-Month Qualifying Event may extend the maximum period of continuation coverage from eighteen (18) months to up to twenty-nine (29) months in the event both of the following occur:

- a. That person (or another person who is entitled to continuation coverage on account of the same 18-Month Qualifying Event) is determined by the Social Security Administration, under Title II or Title XVI of the Social Security Act, to have been disabled before the sixtieth (60<sup>th</sup>) day of continuation coverage; and
- b. The disability status, as determined by the Social Security Administration, lasts at least until the end of the initial eighteen (18) month period of continuation coverage.

The disabled person (or his representative) must submit written proof of the Social Security Administration's disability determination to the *plan administrator* (or its designee) within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the latest of:

- (i.) The date of the disability determination by the Social Security Administration;
- (ii.) The date of the 18-Month Qualifying Event;
- (iii.) The date on which the person loses (or would lose) coverage under this *Plan* as a result of the 18-Month Qualifying Event; or
- (iv.) The date on which the person is furnished with a copy of this Plan Document and Summary Plan Description.

Should the disabled person fail to notify the *plan administrator* (or its designee) in writing within the time frame described above, the disabled person (and others entitled to disability extension on account of that person) will then be entitled to whatever period of continuation he or they would otherwise be entitled to, if any. The *Plan* may require that the individual pay one hundred and fifty percent (150%) of the cost of continuation coverage during the additional eleven (11) months of continuation coverage.

In the event the Social Security Administration makes a final determination that the individual is no longer disabled, the individual must provide notice of that final determination no later than thirty (30) days after the later of:

- (A.) The date of the final determination by the Social Security Administration; or
- (B.) The date on which the individual is furnished with a copy of this Plan Document and Summary Plan Description.

### *END OF CONTINUATION*

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

1. Eighteen (18) months (or twenty-nine (29) months if continuation coverage is extended due to certain disability status as described above) from the date continuation began because of an 18-Month Qualifying Event or the last day of leave under the Family and Medical Leave Act of 1993.
2. Twenty-four (24) months from the date continuation began because of the call-up to military duty.
3. 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.
4. The end of the period for which contributions are paid if the *covered person* fails to make a payment by the date specified by the *plan administrator* (or its designee). In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under this *Plan* or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."
5. The date coverage under this *Plan* ends and the *employer* offers no other group health benefit plan. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.
6. The date the *covered person* first becomes entitled, after the date of the *covered person's* original election of continuation coverage, to *Medicare* benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.
7. The date the *covered person* first becomes covered under any other employer's group health plan after the original date of the *covered person's* election of continuation coverage, but only if such group health plan does not have any exclusion or limitation that affects coverage of the *covered person's* pre-existing condition. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.
8. For the spouse or *dependent* child of a covered *employee* who becomes entitled to *Medicare* prior to the spouse's or *dependent's* election for continuation coverage, thirty-six (36) months from the date the covered *employee* becomes entitled to *Medicare*.

### *SPECIAL RULES REGARDING NOTICES*

1. Any notice required in connection with continuation coverage under this *Plan* must, at minimum, contain sufficient information so that the *plan administrator* (or its designee) is able to determine from such notice the *employee* and *dependent(s)* (if any), the qualifying event or disability, and the date on which the qualifying event occurred.
2. In connection with continuation coverage under this *Plan*, any notice required to be provided by any individual who is either the *employee* or a *dependent* with respect to the qualifying event may be provided by a representative acting on behalf of the *employee* or the *dependent*, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.

3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:
- a. A single notice addressed to both the *employee* and the spouse will be sufficient as to both individuals if, on the basis of the most recent information available to the *Plan*, the spouse resides at the same location as the *employee*; and
  - b. A single notice addressed to the *employee* or the spouse will be sufficient as to each *dependent* child of the *employee* if, on the basis of the most recent information available to the *Plan*, the *dependent* child resides at the same location as the individual to whom such notice is provided.

### *PRE-EXISTING CONDITIONS*

In the event that a *covered person* becomes eligible for coverage under another employer-sponsored group health plan, and that group health plan has an applicable exclusion or limitation regarding coverage of the *covered person's* pre-existing condition, the *covered person's* continuation coverage under the *Plan* will not be affected by enrollment under that other group health plan. This *Plan* shall be primary payer for the *covered expenses* that are excluded or limited under the other employer sponsored group health plan and secondary payer for all other expenses.

### *MILITARY MOBILIZATION*

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

When the leave is less than thirty-one (31) days, the *employee* and the *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 longer, then the *plan administrator* (or its designee) may require the *employee* and the *employee's dependent* to pay no more than one hundred and two percent (102%) of the full contribution.

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

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

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty, the *employee* and the *employee's dependent* will be reinstated without *pre-existing conditions* exclusions or a waiting period, regardless of their election of COBRA continuation coverage.

### *PLAN CONTACT INFORMATION*

Questions concerning this *Plan*, including any available continuation coverage, can be directed to the *plan administrator* (or its designee).

### *ADDRESS CHANGES*

In order to help ensure the appropriate protection of rights and benefits under this *Plan*, *covered persons* should keep the *plan administrator* (or its designee) informed of any changes to their current addresses.

# MEDICAL/DENTAL CLAIM FILING PROCEDURE

A "pre-service claim" is a claim for a *Plan* benefit that is subject to the prior certification rules, as described in the section, *Pre-Service Claim Procedure*. All other claims for *Plan* benefits are "post-service claims" and are subject to the rules described in the section, *Post-Service Claim Procedure*.

## POST-SERVICE CLAIM PROCEDURE

### FILING A CLAIM

1. Claims should be submitted to the *claims processor* at the address noted below:

Aetna  
c/o CoreSource, Inc.  
P.O. Box 2920  
Clinton, IA 52733-2920

The date of receipt will be the date the claim is received by the *claims processor*.

2. All claims submitted for benefits must contain all of the following:

- a. Name of patient.
- b. Patient's date of birth.
- c. Name of *employee*.
- d. Address of *employee*.
- e. Name of *employer* and group number.
- f. Name, address and tax identification number of provider.
- g. *Employee* CoreSource Member Identification Number.
- h. Date of service.
- i. Diagnosis (applies to medical claims ONLY).
- j. Description of service and procedure number.
- k. Charge for service.
- l. The nature of the *accident, injury* or *illness* being treated.

Cash register receipts, credit card copies, labels from containers and cancelled checks are not acceptable.

3. All claims not submitted within six (6) months from the date the services were rendered will not be a *covered expense* and will be denied.

The *covered person* may ask the health care provider to submit the claim directly to the *claims processor* or to the *Preferred Provider Organization* as outlined above, or the *covered person* may submit the bill with a claim form. However, it is ultimately the *covered person's* responsibility to make sure the claim for benefits has been filed.

### NOTICE OF AUTHORIZED REPRESENTATIVE

The *covered person* may provide the *plan administrator* (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a *covered person* and consent to the release of information related to the *covered person* to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

### NOTICE OF CLAIM

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

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than six (6) months after the loss occurs or commences, unless the claimant is legally incapacitated.

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

### ***TIME FRAME FOR BENEFIT DETERMINATION***

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

After a completed claim has been submitted to the *claims processor*, and if additional information is needed for determination of the claim, the *claims processor* will provide the *covered person* (or authorized representative) with a notice detailing information needed. The notice will be provided within thirty (30) calendar days of receipt of the completed claim and will state the date as of which the *Plan* expects to make a decision. The *covered person* will have forty-five (45) calendar days to provide the information requested, and the *Plan* will complete its determination of the claim within fifteen (15) calendar days of receipt by the *claims processor* of the requested information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

### ***NOTICE OF BENEFIT DENIAL***

If the claim for benefits is denied, the *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) with a written Notice of Benefit Denial within the time frames described immediately above.

The Notice of Benefit Denial shall include an explanation of the denial, including:

1. Information sufficient to identify the claim involved.
2. The specific reasons for the denial, to include:
  - a. The denial code and its specific meaning, and
  - b. A description of the *Plan's* standards, if any, used when denying the claim.
3. Reference to the *Plan* provisions on which the denial is based.
4. A description of any additional material or information needed and an explanation of why such material or information is necessary.
5. A description of the *Plan's* claim appeal procedure and applicable time limits.
6. A statement that if the *covered person's* appeal (Refer to *Appealing a Denied Post-Service Claim* below) is denied, the *covered person* has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
7. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
  - a. A copy of that criterion, or
  - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
8. If denial was based on *medical necessity, experimental/investigational* treatment or similar exclusion or limit, the *plan administrator* (or its designee) will supply either:
  - a. An explanation of the scientific or clinical judgment, applying the terms of the *Plan* to the *covered person's* medical circumstances, or
  - b. A statement that such explanation will be supplied free of charge, upon request.

### ***APPEALING A DENIED POST-SERVICE CLAIM***

The "*named fiduciary*" for purposes of an appeal of a denied Post-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the *claims processor*.

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

The following describes the review process and rights of the *covered person*:

1. The *covered person* has the right to submit documents, information and comments and to present evidence and testimony.
2. The *covered person* has the right to access, free of charge, *relevant information* to the claim for benefits.
3. Before a final determination on appeal is rendered, the *covered person* will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the *Plan* in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the *covered person* a reasonable opportunity to respond prior to that date.
4. The review takes into account all information submitted by the *covered person*, even if it was not considered in the initial benefit determination.
5. The review by the *named fiduciary* will not afford deference to the original denial.
6. The *named fiduciary* will not be:
  - a. The individual who originally denied the claim, nor
  - b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
  - a. The *named fiduciary* will consult with a *professional provider* who has appropriate training and experience in the field involving the medical judgment; and
  - b. The *professional provider* utilized by the *named fiduciary* will be neither:
    - (i.) An individual who was consulted in connection with the original denial of the claim, nor
    - (ii.) A subordinate of any other *professional provider* who was consulted in connection with the original denial.
8. If requested, the *named fiduciary* will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

#### ***NOTICE OF BENEFIT DETERMINATION ON APPEAL***

The *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.
2. Reference to specific *Plan* provisions on which the denial is based.
3. A statement that the *covered person* has the right to access, free of charge, *relevant information* to the claim for benefits.
4. A statement of the *covered person's* right to request an external review and a description of the process for requesting such a review.
5. A statement that if the *covered person's* appeal is denied, the *covered person* has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
  - a. A copy of that criterion, or
  - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the denial was based on *medical necessity, experimental/investigational* treatment or similar exclusion or limit, the *plan administrator* (or its designee) will supply either:
  - a. An explanation of the scientific or clinical judgment, applying the terms of the *Plan* to the claimant's medical circumstances, or
  - b. A statement that such explanation will be supplied free of charge, upon request.

## *EXTERNAL APPEAL*

A *covered person*, or the *covered person's* authorized representative, may request a review of a denied claim by making written request to the *named fiduciary* within four (4) months of receipt of notification of the final internal denial of benefits. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. {Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1<sup>st</sup> falls on a Saturday, Sunday or Federal holiday.} The *Plan* may charge a filing fee to the *covered person* requesting an external review, subject to applicable laws and regulations.

## *RIGHT TO EXTERNAL APPEAL*

Within five (5) business days of receipt of the request, the *claims processor* will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that:

1. The *covered person* incurring the claim is or was covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the *Plan* at the time the health care item or service was provided;
2. The final internal denial does not relate to the *covered person's* failure to meet *Plan* eligibility requirements as stated in the section, *Eligibility, Enrollment and Effective Date*;
3. The *covered person* has exhausted the *Plan's* appeal process, to the extent required by law; and
4. The *covered person* has provided all of the information and forms required to complete an external review.

## *NOTICE OF RIGHT TO EXTERNAL APPEAL*

The *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 866-444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the *covered person* to perfect the external review request by the later of the following:
  - a. The four (4) month filing period; or
  - b. Within the forty-eight (48) hour time period following the *covered person's* receipt of notification.

## *INDEPENDENT REVIEW ORGANIZATION*

An Independent Review Organization (IRO) that is accredited by URAC or a similar nationally recognized accrediting organization shall be assigned to conduct the external review. The assigned IRO will timely notify the *covered person* in writing of the request's eligibility and acceptance for external review.

## *NOTICE OF EXTERNAL REVIEW DETERMINATION*

The assigned IRO shall provide the *plan administrator* (or its designee) and the *covered person* (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the *covered person*, the *Plan* and *claims processor*, except to the extent that other remedies may be available under State or Federal law.

## **EXPEDITED EXTERNAL REVIEW**

The *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) the right to request an expedited external review upon the *covered person's* receipt of either of the following:

1. A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the *covered person* or the *covered person's* ability to regain maximum function and the *covered person* has filed an internal appeal request.
2. A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the *covered person* or the *covered person's* ability to regain maximum function or if the final determination involves any of the following:
  - a. An admission,
  - b. Availability of care,
  - c. Continued stay, or
  - d. A health care item or service for which the *covered person* received *emergency services*, but has not been discharged from a *facility*.

Immediately upon receipt of the request for *Expedited External Review*, the *Plan* will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, *Right to External Appeal*.
2. Send notice of the *Plan's* decision, as described in the subsection, *Notice of Right to External Appeal*.

Upon determination that a request is eligible for external review, the *Plan* will do all of the following:

1. Assign an IRO as described in the subsection, *Independent Review Organization*.
2. Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the *covered person's* medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, *Notice of External Review Determination*. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the *plan administrator* (or its designee) and the *covered person* (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

## **FOREIGN CLAIMS**

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

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

## **PRE-SERVICE CLAIM PROCEDURE**

### **HEALTH CARE MANAGEMENT**

*Health care management* is the process of evaluating whether proposed services, supplies or treatments are *medically necessary* and appropriate to help ensure quality, cost-effective care.

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

## FILING A PRE-CERTIFICATION CLAIM

This pre-certification provision will be waived by the *Health Care Management Organization* if the *covered expense* is rendered/provided outside of the continental United States of America or any U.S. Commonwealth, Territory or Possession.

All *inpatient* admissions, partial hospitalizations, *home health care* (excluding supplies and *durable medical equipment*) and *hospice* care are to be certified by the *Health Care Management Organization*. For non-urgent care, the *covered person* (or their authorized representative) must call the *Health Care Management Organization* at least fifteen (15) calendar days prior to initiation of services. If the *Health Care Management Organization* is not called at least fifteen (15) calendar days prior to initiation of services for non-urgent care, benefits may be reduced. For *urgent care*, the *covered person* (or their authorized representative) must call the *Health Care Management Organization* within forty-eight (48) hours or the next business day, whichever is later, after the initiation of services. Please note that if the *covered person* needs medical care that would be considered as *urgent care*, then there is no requirement that the *Plan* be contacted for prior approval.

*Covered persons* shall contact the *Health Care Management Organization* by calling:

1-866-893-6819

When a *covered person* (or authorized representative) calls the *Health Care Management Organization*, he or she should be prepared to provide all of the following information:

1. *Employee's* name, address, phone number and CoreSource Member Identification Number.
2. *Employer's* name.
3. If not the *employee*, the patient's name, address, phone number.
4. Admitting *physician's* name and phone number.
5. Name of *facility, home health care agency or hospice*.
6. Date of admission or proposed date of admission.
7. Condition for which patient is being admitted.

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

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

If the *covered person* (or authorized representative) fails to contact the *Health Care Management Organization* prior to the hospitalization or other care and within the timelines detailed above, the amount of benefits payable for *covered expenses incurred* shall be reduced by \$250. If the *Health Care Management Organization* declines to grant the full pre-certification requested, benefits for days not certified as *medically necessary* by the *Health Care Management Organization* shall be denied. (Refer to *Post-Service Claim Procedure* discussion above.)

## NOTICE OF AUTHORIZED REPRESENTATIVE

The *covered person* may provide the *plan administrator* (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a *covered person* and consent to release of information related to the *covered person* to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department. Notwithstanding the foregoing, requests for pre-certification and other pre-service claims or requests by a person or entity other than the *covered person* may be processed without a written authorization if the request or claim appears to the *plan administrator* (or its designee) to come from a reasonably appropriate and reliable source (e.g., *physician's* office, individuals identifying themselves as immediate relatives, etc.).

## ***FILING A PRE-CERTIFICATION CLAIM***

This pre-certification provision will be waived by the *Health Care Management Organization* if the *covered expense* is rendered/provided outside of the continental United States of America or any U.S. Commonwealth, Territory or Possession.

All *inpatient* admissions, partial hospitalizations, *home health care* (excluding supplies and *durable medical equipment*) and *hospice* care are to be certified by the *Health Care Management Organization*. For non-urgent care, the *covered person* (or their authorized representative) must call the *Health Care Management Organization* at least fifteen (15) calendar days prior to initiation of services. If the *Health Care Management Organization* is not called at least fifteen (15) calendar days prior to initiation of services for non-urgent care, benefits may be reduced. For *urgent care*, the *covered person* (or their authorized representative) must call the *Health Care Management Organization* within forty-eight (48) hours or the next business day, whichever is later, after the initiation of services. Please note that if the *covered person* needs medical care that would be considered as *urgent care*, then there is no requirement that the *Plan* be contacted for prior approval.

***Covered persons shall contact the Health Care Management Organization by calling:***

**1-866-893-6819**

When a *covered person* (or authorized representative) calls the *Health Care Management Organization*, he or she should be prepared to provide all of the following information:

1. *Employee's* name, address, phone number and CoreSource Member Identification Number.
2. *Employer's* name.
3. If not the *employee*, the patient's name, address, phone number.
4. Admitting *physician's* name and phone number.
5. Name of *facility, home health care agency* or *hospice*.
6. Date of admission or proposed date of admission.
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However, *hospital* maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above must be pre-certified.

If the *covered person* (or authorized representative) fails to contact the *Health Care Management Organization* prior to the hospitalization or other care and within the timelines detailed above, the amount of benefits payable for *covered expenses incurred* shall be reduced by \$250. If the *Health Care Management Organization* declines to grant the full pre-certification requested, benefits for days not certified as *medically necessary* by the *Health Care Management Organization* shall be denied. (Refer to *Post-Service Claim Procedure* discussion above.)

## ***NOTICE OF AUTHORIZED REPRESENTATIVE***

The *covered person* may provide the *plan administrator* (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a *covered person* and consent to release of information related to the *covered person* to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department. Notwithstanding the foregoing, requests for pre-certification and other pre-service claims or requests by a person or entity other than the *covered person* may be processed without a written authorization if the request or claim appears to the *plan administrator* (or its designee) to come from a reasonably appropriate and reliable source (e.g., *physician's* office, individuals identifying themselves as immediate relatives, etc.).

## TIME FRAME FOR PRE-SERVICE CLAIM DETERMINATION

1. In the event the *Plan* receives from the *covered person* (or authorized representative) a communication that fails to follow the pre-certification procedure as described above but communicates at least the name of the *covered person*, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the *covered person* (or the authorized representative) will be orally notified (and in writing if requested), within five (5) calendar days of the failure of the proper procedure to be followed.
2. After a completed pre-certification request for non-urgent care has been submitted to the *Plan*, and if no additional information is required, the *Plan* will generally complete its determination of the claim within a reasonable period of time, but no later than fifteen (15) calendar days from receipt of the request.
3. After a pre-certification request for non-urgent care has been submitted to the *Plan*, and if an extension of time to make a decision is necessary due to circumstances beyond the control of the *Plan*, the *Plan* will, within fifteen (15) calendar days from receipt of the request, provide the *covered person* (or authorized representative) with a notice detailing the circumstances and the date by which the *Plan* expects to render a decision. If the circumstances include a failure to submit necessary information, the notice will specifically describe the needed information. The *covered person* will have forty-five (45) calendar days to provide the information requested, and the *Plan* will complete its determination of the claim no later than fifteen (15) calendar days after receipt by the *Plan* of the requested information. Failure to respond in a timely and complete manner will result in a denial.

## CONCURRENT CARE CLAIMS

If an extension beyond the original certification is required, the *covered person* (or authorized representative) shall call the *Health Care Management Organization* for continuation of certification.

1. If a *covered person* (or authorized representative) requests to extend a previously approved hospitalization or an ongoing course of treatment, and;
  - a. The request involves non-urgent care, then the extension request must be processed within fifteen (15) calendar days after the request was received.
  - b. The *inpatient* admission or ongoing course of treatment involves *urgent care*, and
    - (i.) The request is received at least twenty-four (24) hours before the scheduled end of a hospitalization or course of treatment, then the request must be ruled upon and the *covered person* (or authorized representative) notified as soon as possible taking into consideration medical exigencies but no later than twenty-four (24) hours after the request was received; or
    - (ii.) The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment, then the request must be ruled upon and the *covered person* (or authorized representative) notified as soon as possible but no later than seventy-two (72) hours after the request was received; or
    - (iii.) The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment and additional information is required, the *covered person* (or authorized representative) will be notified within twenty-four (24) hours of the additional information required. The *covered person* (or authorized representative) has forty-eight (48) hours to provide such information (may be oral unless written is requested). Upon timely response, the *covered person* (or authorized representative) will be notified as soon as possible but no later than forty-eight (48) hours after receipt of additional information. Failure to submit requested information timely will result in a denial of such request.

If the *Health Care Management Organization* determines that the *hospital* stay or course of treatment should be shortened or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, then the *Health Care Management Organization* shall:

1. Notify the *covered person* of the proposed change, and
2. Allow the *covered person* to file an appeal and obtain a decision, before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved.

If, at the end of a previously approved hospitalization or course of treatment, the *Health Care Management Organization* determines that continued *confinement* is no longer *medically necessary*, additional days will not be certified. (Refer to *Appealing a Denied Pre-Service Claim* discussion below.)

## NOTICE OF PRE-SERVICE CLAIM DENIAL

If a pre-certification request is denied in whole or in part, the *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) with a written Notice of Pre-Service Claim Denial within the time frames above.

The Notice of Pre-Service Claim Denial shall include an explanation of the denial, including:

1. Information sufficient to identify the claim involved.
2. The specific reasons for the denial, to include:
  - a. The denial code and its specific meaning, and
  - b. A description of the *Plan's* standards, if any, used when denying the claim.
3. Reference to the *Plan* provisions on which the denial is based.
4. A description of any additional material or information needed and an explanation of why such material or information is necessary.
5. A description of the *Plan's* claim appeal procedure and applicable time limits.
6. A statement that if the *covered person's* appeal (Refer to *Appealing a Denied Pre-Service Claim* below) is denied, the *covered person* has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
7. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
  - a. A copy of that criterion, or
  - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
8. If denial was based on *medical necessity, experimental/investigational* treatment or similar exclusion or limit, the *plan administrator* (or its designee) will supply either:
  - a. An explanation of the scientific or clinical judgment, applying the terms of the *Plan* to the *covered person's* medical circumstances, or
  - b. A statement that such explanation will be supplied free of charge, upon request.

## APPEALING A DENIED PRE-SERVICE CLAIM

The "*named fiduciary*" for purposes of an appeal of a denied Pre-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the *claims processor*.

A *covered person* (or authorized representative) may request a review of a denied Pre-Service claim by making a verbal or written request to the *named fiduciary* within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the *covered person* feels the claim should not have been denied. If the *covered person* (or authorized representative) wishes to appeal the denial when the services in question have already been rendered, such an appeal will be considered as a separate post-service claim. (Refer to *Post-Service Claim Procedure* discussion above.)

The following describes the review process and rights of the *covered person*:

1. The *covered person* has the right to submit documents, information and comments and to present testimony.
2. The *covered person* has the right to access, free of charge, *relevant information* to the claim for benefits.
3. Before a final determination on appeal is rendered, the *covered person* will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the *Plan* in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the *covered person* a reasonable opportunity to respond prior to that date.
4. The review takes into account all information submitted by the *covered person*, even if it was not considered in the initial benefit determination.
5. The review by the *named fiduciary* will not afford deference to the original denial.
6. The *named fiduciary* will not be:
  - a. The individual who originally denied the claim, nor
  - b. Subordinate to the individual who originally denied the claim.

7. If original denial was, in whole or in part, based on medical judgment:
  - a. The *named fiduciary* will consult with a *professional provider* who has appropriate training and experience in the field involving the medical judgment.
  - b. The *professional provider* utilized by the *named fiduciary* will be neither:
    - (i.) An individual who was consulted in connection with the original denial of the claim, nor
    - (ii.) A subordinate of any other *professional provider* who was consulted in connection with the original denial.
8. If requested, the *named fiduciary* will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

### **NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL**

The *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) with a written Notice of Appeal Decision as soon as possible, but not later than thirty (30) calendar days from receipt of the appeal (not applicable to *urgent care* claims).

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the decision, including:

1. The specific reasons for the denial.
2. Reference to specific *Plan* provisions on which the denial is based.
3. A statement that the *covered person* has the right to access, free of charge, *relevant information* to the claim for benefits.
4. A statement of the *covered person's* right to request an external review and a description of the process for requesting a review.
5. A statement that if the *covered person's* appeal is denied, the *covered person* has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
  - a. A copy of that criterion, or
  - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the denial was based on *medical necessity, experimental/investigational* treatment or similar exclusion or limit, the *plan administrator* (or its designee) will supply either:
  - a. An explanation of the scientific or clinical judgment, applying the terms of the *Plan* to the claimant's medical circumstances, or
  - b. A statement that such explanation will be supplied free of charge, upon request.

### **CASE MANAGEMENT**

In cases where the *covered person's* condition is expected to be or is of a serious nature, the *Health Care Management Organization* may arrange for review and/or case management services from a professional qualified to perform such services. The *plan administrator* 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.

In addition, the *Health Care Management Organization* may recommend (or change) alternative methods of medical care or treatment, equipment or supplies that are *covered expenses* under this *Plan* but on a basis that differs from the alternative recommended by the *Health Care Management Organization*.

The recommended alternatives will be considered as *covered expenses* under the *Plan* provided the expenses can be shown to be viable, *medically necessary*, and are included in a written case management report or treatment plan proposed by the *Health Care Management Organization*.

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

### *SPECIAL DELIVERY PROGRAM*

"Special Delivery" is a voluntary program for expectant mothers offering prenatal information, pre-screening for *pregnancy* related risks and information or preparation for childbirth. This program is designed to identify potential high-risk mothers, as well as help ensure a safer *pregnancy* for both mother and baby.

Expectant mothers who decide to participate in the "Special Delivery" Program will have access to a twenty-four (24) hour toll-free "babyline" which is staffed by obstetrical nurses and will also have a series of four (4) books called "Trimester."

An expectant mother may participate in this program by calling the number shown on her identification card and asking for a "Special Delivery" nurse. If possible, she should call during the first three (3) months of her *pregnancy* in order to receive the full benefits of this program.

## COORDINATION OF BENEFITS

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

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

### DEFINITIONS APPLICABLE TO THIS PROVISION

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

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

This *Plan* is not eligible to be elected as primary coverage in lieu of automobile benefits. Payments from automobile insurance will always be primary and this *Plan* shall be secondary only.

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

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) do not include flexible spending accounts (FSA), health reimbursement accounts (HRA), health savings accounts (HSA), or individual medical, dental or vision insurance policies. "Other Plan" also does not include Tricare, *Medicare*, Medicaid or a state child health insurance program (CHIP). Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for *covered persons* in a group, whether on an insured or uninsured basis, including, but not limited to, *hospital* indemnity benefits and *hospital* reimbursement-type plans;
2. *Hospital* or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage 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 calendar year or that portion of a calendar year during which the *covered person* for whom a claim is made has been covered under this *Plan*.

### ***EFFECT ON BENEFITS***

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

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***

Except as provided below in *Coordination with Medicare*, each plan will make its claim payment according to the first applicable provision in the following list of provisions which determine the order of benefit payment:

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 directly pays before a plan that 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, if any, 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, if any, 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.
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 may be eligible for *Medicare* Part A at no cost if they: (i) are age 65 or older, (ii) have been determined by the Social Security Administration to be disabled, or (iii) have end stage renal disease. Participation in *Medicare* Part B and D is available to all individuals who make application and pay the full cost of the coverage.

1. When an *employee* becomes entitled to *Medicare* coverage (due to age or disability) 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 (due to age or disability) 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* are also enrolled in *Medicare* (due to age or disability), this *Plan* shall pay as the primary plan. If, however, the *Medicare* enrollment is due to end stage renal disease, the *Plan's* primary payment obligation will end at the end of the thirty (30) month "coordination period" as provided in *Medicare* law and regulations.
4. Notwithstanding Paragraphs 1 to 3 above, if the *employer* (including certain affiliated entities that are considered the same employer for this purpose) has fewer than one hundred (100) *employees*, when a covered *dependent* becomes entitled to *Medicare* coverage due to total disability, as determined by the Social Security Administration, and the *employee* is actively-at-work, *Medicare* will pay as the primary payer for claims of the *dependent* and this *Plan* will pay secondary.
5. 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.
6. For a *retiree* eligible for *Medicare* due to age, *Medicare* shall be the primary payor and this *Plan* shall be secondary.

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

## LIMITATIONS ON PAYMENTS

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

## RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

## FACILITY OF BENEFIT PAYMENT

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

## *AUTOMOBILE ACCIDENT BENEFITS*

The *Plan's* liability for expenses arising out of an automobile accident shall always be secondary to any automobile insurance, irrespective of the type of automobile insurance law that is in effect in the *covered person's* state of residence. Currently, there are three (3) types of state automobile insurance laws.

1. No-fault automobile insurance laws
2. Financial responsibility laws
3. Other automobile liability insurance laws

No Fault Automobile Insurance Laws. In no event will the *Plan* pay any claim presented by or on behalf of a *covered person* for medical benefits that would have been payable under an automobile insurance policy but for an election made by the principal named insured under the automobile policy that reduced covered levels and/or subsequent premium. This is intended to exclude, as a *covered expense*, a *covered person's* medical expenses arising from an automobile accident that are payable under an automobile insurance policy or that would have been payable under an automobile insurance policy but for such an election.

1. In the event a *covered person* incurs medical expenses as a result of *injuries* sustained in an automobile accident while "covered by an automobile insurance policy," as an operator of the vehicle, as a passenger, or as a pedestrian, benefits will be further limited to medical expenses, that would in no event be payable under the automobile insurance; provided however that benefits payable due to a required deductible under the automobile insurance policy will be paid by the *Plan* up to the amount equal to that deductible.
2. For the purposes of this section the following people are deemed "covered by an automobile insurance policy."
  - a. An owner or principal named insured individual under such policy.
  - b. A family member of an insured person for whom coverage is provided under the terms and conditions of the automobile insurance policy.
  - c. Any other person who, except for the existence of the *Plan*, would be eligible for medical expense benefits under an automobile insurance policy.

Financial Responsibility Laws. The *Plan* will be secondary to any potentially applicable automobile insurance even if the state's "financial responsibility law" does not allow the *Plan* to be secondary.

Other Automobile Liability Insurance. If the state does not have a no-fault automobile insurance law or a "financial responsibility" law, the *Plan* is secondary to automobile insurance coverage or to any other person or entity who caused the *accident* or who may be liable for the *covered person's* medical expenses pursuant to the general rule for *Subrogation/Reimbursement*.

## SUBROGATION/REIMBURSEMENT

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

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

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

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

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

3. **Assisting in *Plan's* Reimbursement Activities.** The *covered person* has an obligation to assist the *Plan* to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the *covered person*, and to provide the *Plan* with any information concerning the *covered person's* other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the *covered person*. The *covered person* is required to (a) cooperate fully in the *Plan's* (or any *Plan* fiduciary's) enforcement of the terms of the *Plan*, including the exercise of the *Plan's* right to subrogation

and reimbursement, whether against the *covered person* or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the *Plan* as a co-payee for the amount of the Reimbursable Payments and notifying the *Plan*), (c) sign any document deemed by the *plan administrator* to be relevant to protecting the *Plan's* subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the *plan administrator* or *claims processor* to enforce the *Plan's* rights.

The *plan administrator* has delegated to the *claims processor* for medical/dental claims the right to perform ministerial functions required to assert the *Plan's* rights with regard to such claims and benefits; however, the *plan administrator* shall retain discretionary authority with regard to asserting the *Plan's* recovery rights.

# GENERAL PROVISIONS

## ADMINISTRATION OF THE PLAN

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

The *employer* is the *named fiduciary* of the *Plan* except as noted herein. Except as otherwise specifically provided in this document, the *claims processor* is the *named fiduciary* of the *Plan* for pre-service and post-service claim appeals (this may be different if an outside vendor is involved). As the *named fiduciary* for appeals, the *claims processor* maintains discretionary authority to review all denied claims under appeal for benefits under the *Plan*. The *employer* maintains discretionary authority to interpret the terms of the *Plan*, including but not limited to, determination of eligibility for and entitlement to *Plan* benefits in accordance with the terms of the *Plan*; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

## APPLICABLE LAW

All provisions of the *Plan* shall be construed and administered in a manner consistent with the requirements under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

## ASSIGNMENT

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

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

This *Plan* will pay benefits to the responsible party of an *alternate recipient* as designated in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

## BENEFITS NOT TRANSFERABLE

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

## CLERICAL ERROR

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

## CONFORMITY WITH STATUTE(S)

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

### *EFFECTIVE DATE OF THE PLAN*

The *effective date* of this *Plan* is January 1, 2011.

### *FRAUD OR INTENTIONAL MISREPRESENTATION*

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

### *FREE CHOICE OF HOSPITAL AND PHYSICIAN*

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

### *INCAPACITY*

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

### *INCONTESTABILITY*

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

### *LEGAL ACTIONS*

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

### *LIMITS ON LIABILITY*

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

## *LOST DISTRIBUTEES*

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

## *MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS*

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

## *PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN*

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

## *PLAN IS NOT A CONTRACT*

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

## *PLAN MODIFICATION AND AMENDMENT*

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

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

## *PLAN TERMINATION*

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

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

### *PRONOUNS*

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

### *RECOVERY FOR OVERPAYMENT*

Whenever payments have been made from the *Plan* in excess of the maximum amount of payment necessary, the *Plan* will have the right to recover these excess payments. If the *Plan* 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 *Plan's* or the *Plan* designee's own error, from the person or entity to whom it was made or from any other appropriate party.

### *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 continuous coverage with respect to any *pre-existing condition* limitation, deductible(s), *coinsurance* and *maximum benefit*.

### *TIME EFFECTIVE*

The effective time with respect to any dates used in the *Plan* shall be 12:01 a.m. 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.

# HIPAA PRIVACY

The following provisions are intended to comply with applicable *Plan* amendment requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (*HIPAA*).

## *DISCLOSURE BY PLAN TO PLAN SPONSOR*

The *Plan* may take the following actions only upon receipt of a *Plan* amendment certification:

1. Disclose protected health information to the *plan sponsor*.
2. Provide for or permit the disclosure of protected health information to the *plan sponsor* by a health insurance issuer or HMO with respect to the *Plan*.

## *USE AND DISCLOSURE BY PLAN SPONSOR*

The *plan sponsor* may use or disclose protected health information received from the *Plan* to the extent not inconsistent with the provisions of this *HIPAA Privacy* section or the *privacy rule*.

## *OBLIGATIONS OF PLAN SPONSOR*

The *plan sponsor* shall have the following obligations:

1. Ensure that:
  - a. Any agents (including a subcontractor) to whom it provides protected health information received from the *Plan* agree to the same restrictions and conditions that apply to the *plan sponsor* with respect to such information; and
  - b. Adequate separation between the *Plan* and the *plan sponsor* is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(iii).
2. Not use or further disclose protected health information received from the *Plan*, other than as permitted or required by the *Plan* documents or as *required by law*.
3. Not use or disclose protected health information received from the *Plan*:
  - a. For employment-related actions and decisions; or
  - b. In connection with any other benefit or employee benefit plan of the *plan sponsor*.
4. Report to the *Plan* any use or disclosure of the protected health information received from the *Plan* that is inconsistent with the use or disclosure provided for of which it becomes aware.
5. Make available protected health information received from the *Plan*, as and to the extent required by the *privacy rule*:
  - a. For access to the individual;
  - b. For amendment and incorporate any amendments to protected health information received from the *Plan*; and
  - c. To provide an accounting of disclosures.
6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the *Plan* available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the *Plan* with the *privacy rule*.

7. Return or destroy all protected health information received from the *Plan* that the *plan sponsor* still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the *Plan* was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
8. Provide protected health information only to those individuals, under the control of the *plan sponsor* who perform administrative functions for the *Plan*; (*i.e.*, eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for *Plan* administrative functions nor to release protected health information to an unauthorized individual.
9. Provide protected health information only to those entities required to receive the information in order to maintain the *Plan* (*i.e.*, claim administrator, case management vendor, pharmacy benefit manager, claim subrogation, vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the *Plan*).
10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.
11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the *plan sponsor* on behalf of the *Plan*. Specifically, such safeguarding entails an obligation to:
  - a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the *plan sponsor* creates, receives, maintains, or transmits on behalf of the *Plan*;
  - b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
  - c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
  - d. Report to the *Plan* any security incident of which it becomes aware.

### EXCEPTIONS

Notwithstanding any other provision of this *HIPAA Privacy* section, the *Plan* (or a health insurance issuer or HMO with respect to the *Plan*) may:

1. Disclose summary health information to the *plan sponsor*:
  - a. If the *plan sponsor* requests it for the purpose of:
    - (i.) Obtaining premium bids from health plans for providing health insurance coverage under the *Plan*; or
    - (ii.) Modifying, amending, or terminating the *Plan*;
2. Disclose to the *plan sponsor* information on whether the individual is participating in the *Plan*, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the *Plan*;
3. Use or disclose protected health information:
  - a. With (and consistent with) a valid authorization obtained in accordance with the *privacy rule*;
  - b. To carry out treatment, payment, or health care operations in accordance with the *privacy rule*; or
  - c. As otherwise permitted or required by the *privacy rule*.

## DEFINITIONS

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

### ***Accident***

An unforeseen event resulting in *injury*.

### ***Aetna Negotiated Rate***

The rate *Aetna Preferred Providers* have contracted to accept as payment in full for *covered expenses* of the *Plan*.

### ***Aetna Preferred Provider***

A *physician, hospital* or other health care provider who has an agreement in effect with Aetna or an Affiliate of Aetna at the time services are rendered. *Aetna Preferred Providers* agree to accept the *negotiated rate* as payment in full.

### ***Aetna Preferred Provider Organization***

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

### ***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 *Medicare*; or that has a contract with the *Preferred Provider Organization* as a *preferred provider*. An *ambulatory surgical facility* is a *facility* that:

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*; and
5. Is affiliated with or part of a *hospital*.

### ***Birth Center***

A *facility* that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

### ***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 (diagnostic and statistical manual of mental disorders) criteria.

### ***Chiropractic Care***

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

### ***Claims Processor***

Refer to the *Summary Plan Description (SPD)* section 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 expenses* payable by the *Plan* for benefits that are provided under the *Plan*. The *coinsurance* is applied to *covered expenses* after the deductible(s) have been met, if applicable.

### ***Complications of Pregnancy***

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

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

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

### ***Concurrent Care***

A request by a *covered person* (or their authorized representative) to the *Health Care Management Organization* prior to the expiration of a *covered person's* current course of treatment to extend such treatment OR a determination by the *Health Care Management Organization* to reduce or terminate an ongoing course of treatment.

### **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*.

### **Copay**

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

### **Cosmetic Surgery**

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

### **Covered Expenses**

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

### **Covered Person**

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

### **Custodial Care**

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

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

### **Customary and Reasonable Amount**

Any negotiated fee (where the provider has contracted to accept such fee as payment in full for *covered expenses* of the *Plan*) assessed for services, supplies or treatment by a *nonpreferred provider*, or a fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is *incurred* and is comparable in severity and nature to the *illness or injury*. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. Except as to negotiated fees, the *customary and reasonable amount* is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges. The percentage applicable to this *Plan* is 80% and is applied to CPT and CDT codes or HIAA Code Analysis using MDR or HIAA tables.

### **Dentist**

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a *close relative* of the *covered person*, who is practicing within the scope of his license.

### ***Dependent***

For information regarding eligibility for *dependents*, refer to the *Eligibility, Enrollment and Effective Date, Dependent(s) Eligibility* section of this document.

### ***Durable Medical Equipment***

Medical equipment which:

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

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

### ***Effective Date***

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

### ***Emergency***

An accidental *injury*, or the sudden onset of an *illness* where the acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the *covered person's* life (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious 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, as reported on the individual's annual W-2 form, by the *employer*, who is regularly scheduled to work not less than thirty-five (35) hours per work week on a *full-time* status basis or who is regularly scheduled to work not less than twenty-six (26) hours per work week on a *part-time* status basis.

### ***Employer***

The *employer* is Township of Pemberton.

### ***Enrollment Date***

A *covered person's enrollment date* is the first day of any applicable service waiting period or the date of hire. For a *covered person* who enrolls in the *Plan* as the result of a Special Enrollment Period or as the result of an open enrollment period, if available, the *enrollment date* is the first date of coverage.

### *Experimental/Investigational*

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

The *claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator*, or their designee must make an independent evaluation of the *experimental/non-experimental* standings of specific technologies. The *claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator* or their designee shall be guided by a reasonable interpretation of *Plan* provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The *claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator* or their designee will be guided by the following examples of *experimental* services and supplies:

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, was not 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 ongoing Phase I or Phase II clinical trials, is in the research, *experimental*, study or *investigational* arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

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

### *Extended Care Facility*

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

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

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

### **Facility**

A healthcare institution which meets all applicable state or local licensure requirements.

### **Freestanding Surgicenter**

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 *Medicare*; or that has a contract with the *Preferred Provider Organization* as a *preferred provider*. A *freestanding surgicenter* is a *facility* that:

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 *freestanding surgicenter*;
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*; and.
5. Is not affiliated with or part of any *hospital*.

### **Full-time**

*Employees* who are regularly scheduled to work not less than thirty-five (35) hours per work week.

### **Generic Drug**

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

### **Health Care Management**

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

### **Health Care Management Organization**

The individual or organization designated by the *employer* for the process of evaluating whether the service, supply, or treatment is *medically necessary*. The *Health Care Management Organization* is CoreSource, Inc.

### **Home Health Aide Services**

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**

Includes the following services: skilled nursing visits, *hospice* and IV Infusion therapy for the purposes of pre-service claims only.

### *Home Health Care Agency*

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

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

### *Hospice*

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

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

### *Hospital*

An institution which meets the following conditions:

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

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 physical rehabilitative services where the *covered person* received treatment as a result of an *illness* or *injury*.

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

#### ***Illness***

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

#### ***In-Store Health Clinic***

A medical clinic located within a larger retail operation that offers convenient, general medical services to the public, that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

*In-store health clinics* are generally staffed by non-*physician* providers such as physician assistants or nurse practitioners who are able to provide basic treatment and write prescriptions. *In-store health clinics* shall not include specialty clinics, such as providers of eye care, or clinics offering care on a one-time or seasonal basis, such as clinics offering only flu vaccinations.

#### ***Incurred or Incurred Date***

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

#### ***Injury***

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

#### ***Inpatient***

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

#### ***Intensive Care***

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

#### ***Intensive Care Unit***

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

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

This term does not include care in a surgical recovery room, but does include cardiac care unit or any such other similar designation.

### **Maximum Benefit**

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

1. The maximum amount paid by this *Plan* for any one *covered person* for a particular *covered expense*. The maximum amount can be for:
  - a. The entire time the *covered person* is covered under this *Plan*, or
  - b. A specified period of time, such as a calendar year.
2. The maximum number as outlined in the *Plan* as a *covered expense*. The maximum number relates to the number of:
  - a. Treatments during a specified period of time, or
  - b. Days of *confinement*.

### **Medically Necessary (or Medical Necessity)**

Service, supply or treatment which is determined by the *claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator* or their designee to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the *covered person's illness or injury* and which could not have been omitted without adversely affecting the *covered person's* condition or the quality of the care rendered; and
2. Supplied or performed in accordance with current standards of medical practice within the United States; and
3. Not primarily for the convenience of the *covered person* or the *covered person's* family or *professional provider*; and
4. Is an appropriate supply or level of service that safely can be provided; and
5. Is recommended or approved by the attending *professional provider*.

The fact that a *professional provider* may prescribe, order, recommend, perform or approve a service, supply or treatment does not, in and of itself, make the service, supply or treatment *medically necessary* and the *claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator* or their designee, may request and rely upon the opinion of a *physician* or *physicians*. The determination of the *claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator* or their designee shall be final and binding.

### **Medicare**

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

### **Mental and Nervous Disorder**

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM (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.

### **Morbid Obesity**

A diagnosed condition in which the body weight is one hundred (100) pounds or more over the medically recommended weight in the most recent Metropolitan Life Insurance Company tables for a person of the same height,

age and mobility as the *covered person*, or having a BMI (body mass index) of forty (40) or higher, or having a BMI of thirty-five (35) in conjunction with any of the following co-morbidities: coronary artery disease, type II diabetes, clinically significant obstructive sleep apnea or medically refractory hypertension (blood pressure > 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management).

***Named Fiduciary for Post-Service Claim Appeals***

CoreSource.

***Named Fiduciary for Pre-Service Claim Appeals***

CoreSource.

***Negotiated Rate***

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

***Nonparticipating Pharmacy***

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

***Nonpreferred Provider***

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

***Nurse***

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

***Outpatient***

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

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

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

***Partial Confinement***

A period of at least six (6) hours but less than twenty-four (24) hours per day of active treatment up to five (5) days per week 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. *Chemical dependency* treatment.

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

***Participating Pharmacy***

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

***Part-time***

*Employees* who are regularly scheduled to work less than twenty-six (26) hours per work week.

***Pharmacy Organization***

The *pharmacy organization* is Caremark.

***Physician***

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a *close relative* of the *covered person* who is practicing within the scope of his license.

***Placed For Adoption***

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

***Plan***

"*Plan*" refers to the benefits and provisions for payment of same as described herein. The *Plan* is the Township of Pemberton Medical Benefit Plan.

***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 Township of Pemberton.

***Plan Year End***

The *plan year end* is December 31.

***Pre-existing Conditions***

An *illness* or *injury* which existed within three (3) months before the *covered person's enrollment date* for coverage under this *Plan*. An *illness* or *injury* is considered to have existed when the *covered person*:

1. Sought or received professional advice for that *illness* or *injury*, or
2. Received medical care or treatment for that *illness* or *injury*, or
3. Received medical supplies, drugs, or medicines for that *illness* or *injury*.

***Preferred Provider***

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

***Preferred Provider Organization***

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

***Pregnancy***

The physical state which results in childbirth or miscarriage.

***Primary Care Physician (PCP)***

A licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is a general or family practitioner, pediatrician, general internist or obstetrician/gynecologist.

***Privacy Rule***

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulation concerning privacy of individually identifiable health information, as published in 65 Fed. Reg. 82461 (Dec. 28, 2000) and as modified and published in 67 Fed. Reg. 53181 (Aug. 14, 2002).

***Professional Provider***

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

- Audiologist
- Certified Addictions Counselor
- Certified Registered Nurse Anesthetist
- Chiropractor
- Clinical Laboratory
- Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)
- Dental Hygienist
- Dentist
- Dietitian
- Dispensing Optician
- Licensed Pastoral Counselor
- Midwife
- Nurse (R.N., L.P.N., L.V.N., D.N.P.)
- Nurse Practitioner
- Occupational Therapist
- Optician
- Optometrist
- Physical Therapist
- Physician
- Physician's Assistant
- Podiatrist
- Psychologist
- Respiratory Therapist
- Speech Therapist

***Qualified Prescriber***

A *physician, dentist* or other health care practitioner who may, in the legal scope of their license, prescribe drugs or medicines.

***Reconstructive Surgery***

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

***Relevant Information***

*Relevant information*, when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:

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

***Required By Law***

The same meaning as the term "required by law" as defined in 45 CFR 164.501, to the extent not preempted by ERISA or other Federal law.

***Retiree***

A former *employee* who retired from service of the *employer* and has met the *Plan's* eligibility requirements to continue coverage under the *Plan* as a *retiree*. As used in this document, the term *employee* shall include *retirees* covered under the *Plan*.

***Room and Board***

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

***Semiprivate***

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

***Specialist Physician***

A *professional provider* who is other than a *primary care physician*.

***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*.
  - c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the *covered person*.
  - d. It provides at least the following basic services:
    - (i.) *Room and board*
    - (ii.) Evaluation and diagnosis
    - (iii.) Counseling
    - (iv.) Referral and orientation to specialized community resources.

***Urgent Care***

An *emergency* or an onset of severe pain that cannot be managed without immediate treatment.

***Urgent Care Center***

A *facility* which is engaged primarily in providing minor emergency and episodic medical care and which has:

1. a board-certified *physician*, a Registered Nurse (RN) and a registered x-ray technician in attendance at all times;
2. has x-ray and laboratory equipment and life support systems.

An *urgent care center* may include a clinic located at, operated in conjunction with, or which is part of a regular *hospital*.