AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Gunnison County Employee Medical Benefit Plan; Cor

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement: Gunnison County, Colorado

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Gunnison County, Colorado Employee Medical Benefit Plan effective January 1, 2019 replaces the existing Medical Benefit Plan restated effective September 1, 2017.

Fiscal Impact:

Submitted by: Cheryl Seling **Submitter's Email Address:** cseling@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ◉ Required ○ Not Required

Comments:
ok db 3/27/19

Reveiwed by: GUNCOUNTY1\dBaumgarten Discharge Date: 3/27/2019 Certificate of Insurance Required Yes ○ No ◉

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 3/27/2019

◉ Consent Agenda ○ Regular Agenda ○ Worksession Time Allotted: 0

Agenda Date: 4/2/2019

Revised April 2015

GUNNISON COUNTY, COLORADO

EMPLOYEE MEDICAL BENEFIT PLAN

PLAN DOCUMENT

Effective Date: January 1, 2019

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FACTS ABOUT THE PLAN

Name of Plan:

Gunnison County, Colorado Employee Medical Benefit Plan

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

Gunnison County, Colorado
200 E. Virginia Avenue
Gunnison, Colorado 81230
(970) 641-7623

Employer Identification Number:

84-6000770

Plan Number:

501

Group Number:

GU

Type of Plan:

Welfare Benefit Plan: medical 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:

Gunnison County, Colorado
200 E. Virginia Avenue
Gunnison, Colorado 81230
(970) 641-7623

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 section, *Eligibility, Enrollment and Effective Date*.

For detailed information regarding a person being ineligible for benefits through reaching ***Essential Health Benefit/***non-***Essential Health Benefit maximum benefit*** levels, termination of coverage or ***Plan*** exclusions, refer to the following sections:

Schedule of Benefits
Termination of Coverage
Plan Exclusions

Source of Plan Contributions:

Contributions for ***Plan*** expenses are obtained from the ***employer*** and from covered ***employees***. The ***employer*** evaluates the costs of the ***Plan*** based on projected ***Plan*** expenses and determines the amount to be contributed by the ***employer*** and the amount to be contributed by the covered ***employees***. Contributions by the covered ***employees*** are deducted from their pay on a pre-tax basis as authorized by the ***employee*** on the enrollment form (whether paper or electronic) or other applicable forms.

Funding Method:

The ***employer*** pays ***Plan*** benefits and administration expenses directly from general assets. Contributions received from ***covered persons*** are used to cover ***Plan*** costs and are expended immediately.

Ending Date of Plan Year:

December 31st

Standards Relating to Benefits for Mothers and Newborns:

If the *Schedule of Benefits* shows that you have coverage for ***pregnancy*** and newborn care, this ***Plan*** 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 vaginal delivery, or less than ninety-six (96) hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, this ***Plan*** may not, under Federal law, require that a provider obtain authorization from the ***Plan*** for prescribing a length of stay not in excess of the above periods.

Preferred Provider Networks**:**

This ***Plan*** may contain a ***Preferred Provider Organization*** (PPO) network and pre-certification requirements. Refer to the ***Plan*** for detailed information concerning pre-certification and ***Preferred Provider*** requirements. For a listing of ***Preferred Providers***, contact the PPO network listed on your identification card.

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 Claim Filing Procedure*.

The designated ***claims processor*** for medical claims is:

CoreSource, Inc.
P.O. Box 2310
Mt. Clemens, MI 48046
Covered persons: (877) 848-9984
Providers: (800)-999-0114

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

CVS Caremark
750 W. John Carpenter Freeway, Suite 600
Irving, TX 75039
(866) 818-6911

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Medical Filing Procedure, Medical Expense Benefit, Medical Exclusions, Prescription Drug Program,* and *Plan Exclusions*.

Medical Benefits:

Benefit Period: January 1 – December 31

MEDICAL BENEFITS – TRADITIONAL PLAN	
Medical Deductible *(per benefit period)*	
Individual	$800
Family (embedded)	$1,600
Generally, each ***covered person*** must pay all of the medical costs from providers up to the medical deductible amount before the ***Plan*** begins to pay. The medical deductible is calculated separately from the prescription deductible. **Embedded Family Deductible**: Each ***covered person*** in the family must satisfy the individual embedded medical deductible until the family medical deductible has been satisfied, before this ***Plan*** begins to pay for covered medical expenses that are subject to the deductible.	
Medical Out-of-Pocket Expense Limit (includes deductible, ***coinsurance***, medical ***copays***)	
Individual	$3,200
Family (embedded)	$6,400
The out-of-pocket expense limit is the most the ***covered person*** could pay in a year for covered services. The medical out-of-pocket expense limit is calculated separately from the prescription drug out-of-pocket expense limit. **Embedded Family Out-of-Pocket Expense Limit:** Each ***covered person*** in the family must satisfy the individual embedded medical out-of-pocket expense limit until the family medical out-of-pocket expense limit has been satisfied. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.	
Standard *coinsurance* paid by the *Plan*	80%

MEDICAL BENEFITS – TRADITIONAL PLAN	***Facilities/Preferred Provider/Nonpreferred Provider*** (% of ***negotiated rate*** or ***allowable claim limit***, if applicable)
Allergy Services *(includes **physician** office visit and **urgent care center**)*	
Allergy injections	80% after Deductible
Allergy serum	80% after Deductible
Allergy testing	80% after Deductible
Ambulance	
Land	80% after Deductible
Air	80% after Deductible

MEDICAL BENEFITS – TRADITIONAL PLAN	***Facilities/Preferred Provider/Nonpreferred Provider*** (% of ***negotiated rate*** or ***allowable claim limit***, if applicable)
Applied Behavior Analysis Therapy (ABA)	Not Covered
Bereavement Counseling	80% after Deductible
Birthing Center	80% after Deductible
Blood *(Blood storage and transfusions)*	80% after Deductible
Cardiac Rehabilitation	
Facility	80% after Deductible
Physician	80% after Deductible
Chemotherapy	
Facility	80% after Deductible
Physician	80% after Deductible
Chiropractic Care Office visits, spinal manipulation, adjustments and x-rays	80% after Deductible Maximum: $500 per Benefit Period
Complementary/Alternative Medicine *(includes Acupuncture/Acupressure, Therapeutic Massage, Nutrition Therapy, Rolfing, and Naturopathy Care)*	$40 ***Copay*** Deductible Waived Maximum: $1,000 per Benefit Period
Contraceptives	See Women's Preventive Services
Diagnostic Services – Major *(such as MRI, CT Scan, PET Scan)*	80% after Deductible
Diagnostic Services – Minor	
X-rays	80% after Deductible
Laboratory services (including independent labs)	80% after Deductible
Other diagnostic services	80% after Deductible
Dialysis Therapy or Treatment	
Facility	80% after Deductible
Physician	80% after Deductible
Durable Medical Equipment	80% after Deductible
Emergency Services – (for an ***emergency***)	
Facility	80% after Deductible
Physician	80% after Deductible
Emergency Services – (not for an ***emergency***)	
Facility	80% after Deductible
Physician	80% after Deductible

MEDICAL BENEFITS – TRADITIONAL PLAN	***Facilities/Preferred Provider/Nonpreferred Provider*** (% of ***negotiated rate*** or ***allowable claim limit***, if applicable)
Hearing	
Routine Exam, Testing	80% after Deductible
Hearing Aids and Devices	80% after Deductible
Cochlear Implants	Not Covered
	Maximum: $4,500 per 5 Year Period
Home Health Care *(pre-certification required)*	
Home health care visits	80% after Deductible
Home health care supplies & services	80% after Deductible
IV therapy	80% after Deductible
	Maximum: 120 Visits per Benefit Period
Hospice Care *(pre-certification required)*	
Inpatient	80% after Deductible
Outpatient	80% after Deductible
Hospital – Inpatient *(pre-certification required)*	
Facility	80% after Deductible
Physician/Surgeon	80% after Deductible
Anesthesia, Radiology, Pathology, Lab	80% after Deductible
Hospital – Outpatient & Ambulatory Surgical Facility	
Facility	80% after Deductible
Physician/Surgeon	80% after Deductible
Anesthesia, Radiology, Pathology, Lab	80% after Deductible
Infertility Services	
Diagnostic testing to determine infertility	80% after Deductible
Surgical procedures to correct infertility	80% after Deductible
Medications and treatments	Not Covered
Infusion Therapy	
Facility	80% after Deductible
Physician	80% after Deductible
Injectables *(See Allergy Services for allergy shots)*	
Office visit	80% after Deductible
Outpatient	80% after Deductible

MEDICAL BENEFITS – TRADITIONAL PLAN	***Facilities/Preferred Provider/Nonpreferred Provider*** (% of ***negotiated rate*** or ***allowable claim limit***, if applicable)
Mental and Nervous Disorders and Substance Abuse	
Inpatient *(pre-certification required)*	80% after Deductible
Outpatient visit	80% after Deductible
Office Visits	
Gunnison County Family Physicians	$20 ***Copay*** Deductible Waived
Primary care physician	$40 ***Copay*** Deductible Waived
Specialist	$60 ***Copay*** Deductible Waived
Outpatient other services	80% after Deductible
Office Visit & Other Services	
Office Visit/Consultation	
Gunnison County Family Physicians	$20 ***Copay*** Deductible Waived
Primary care physician	$40 ***Copay*** Deductible Waived
Specialist	$60 ***Copay*** Deductible Waived
Injectables	80% after Deductible
Surgery	80% after Deductible
X-ray, lab, minor diagnostics	80% after Deductible
Other services	80% after Deductible
Orthotics	80% after Deductible
Podiatry Services	Based on Service Provided
Pregnancy	
Initial pre-natal visit and urinalysis	100% Deductible Waived
Subsequent pre-natal visits/care and breastfeeding services and supplies (as required by the ***Affordable Care Act***)	100% Deductible Waived
Post-natal care and other non-routine/non-preventive pregnancy related care.	Based on Service Provided
Delivery	80% after Deductible
Private Duty Nursing	
Inpatient	Not Covered
Outpatient	Not Covered
Prostate Examinations	100% Deductible Waived
Prostheses	80% after Deductible
Radiation Therapy	
Facility	80% after Deductible
Physician	80% after Deductible

MEDICAL BENEFITS – TRADITIONAL PLAN	***Facilities/Preferred Provider/Nonpreferred Provider*** (% of ***negotiated rate*** or ***allowable claim limit***, if applicable)
Respiratory Therapy ***Facility*** ***Physician***	 80% after Deductible 80% after Deductible
Retail Clinic	$40 ***Copay*** Deductible Waived
Routine Preventive Care/Wellness Benefits Includes all 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). For additional information visit: http://www.uspreventiveservicestaskforce.org	100% Deductible Waived
Skilled Nursing Facility *(pre-certification required)*	80% after Deductible Maximum: 120 Days per ***Confinement***
Sterilization Male Female	 80% after Deductible See Women's Preventive Services
Temporomandibular Joint Syndrome (TMJ) Treatment (Does not include orthodontia or dental appliances)	Based on Service Provided
Therapy Services *(physical, speech and occupational)* ***Facility*** ***Physician***	 80% after Deductible 80% after Deductible Maximum : 60 Visits each per Benefit Period for Physical, Occupational and Speech Therapy
Transplants (Organ or Tissue) *(pre-certification required)* ***Facility*** ***Physician*** Travel	 80% after Deductible 80% after Deductible 80% after Deductible
Urgent Care Facility Visit All other services	 80% Deductible Waived 80% Deductible Waived
Vision – Routine Services *(Routine vision services required by the **Affordable Care Act** shall be covered under the Routine Preventive Care benefit)*	Not Covered

MEDICAL BENEFITS – TRADITIONAL PLAN	***Facilities/Preferred Provider/Nonpreferred Provider*** (% of ***negotiated rate*** or ***allowable claim limit***, if applicable)
Weight Loss Services	
Treatment of obesity (other than ***morbid obesity***)	Not Covered
Treatment of ***morbid obesity***	
Surgical treatment	Based on Service Provided
Non-surgical treatment and programs	Based on Service Provided
Wigs	Not Covered
Women's Preventive Services As required by the ***Affordable Care Act***	100% Deductible Waived
All Other C*overed Expenses*	80% after Deductible

PRE-CERTIFICATION REQUIREMENTS
Inpatient Admissions (***hospital***, rehabilitation, ***skilled nursing facility***, transplant)
Partial Confinements
Home Health Care (including infusions)
Hospice Care
Transplants

PRESCRIPTION DRUG BENEFITS – TRADITIONAL PLAN	*Participating Pharmacies*	*Nonparticipating Pharmacies*
Prescription Drug Deductible *(per benefit period)*		
Individual	$100	Not Applicable
Generally, each ***covered person*** must pay all of the prescription costs up to the prescription drug deductible amount before the ***Plan*** begins to pay. The medical deductible is calculated separately from the prescription drug deductible.		
Prescription Drug Out-of-Pocket Expense Limit		
Individual	$3,000	Not Applicable
Family (embedded)	$6,000	Not Applicable
The prescription drug out-of-pocket expense limit is the most the ***covered person*** could pay in a year for covered prescription drugs. The medical out-of-pocket expense limit is calculated separately from the prescription drug out-of-pocket expense limit. **Embedded Family Prescription Out-of-Pocket Expense Limit:** Each ***covered person*** in the family must satisfy the individual embedded prescription drug out-of-pocket expense limit until the family prescription drug out-of-pocket expense limit has been satisfied. The ***Plan*** will pay the designated percentage of ***covered expenses*** and will apply the applicable ***copay*** after the prescription drug deductible until the prescription drug out-of-pocket expense limits are reached, at which time the ***Plan*** will pay 100% of the remainder of ***covered expenses*** for the rest of the benefit period unless stated otherwise.		
Retail Pharmacy (30-day supply, unless otherwise specified)		
Routine preventive drugs required by the ***Affordable Care Act***	100% Deductible Waived	Not Applicable
Generic		
30-day supply	$5 ***Copay*** after Deductible	Not Covered
60-day supply	$10 ***Copay*** after Deductible	Not Covered
90-day supply	$15 ***Copay*** after Deductible	Not Covered
Formulary Brand Name	75% after Deductible (Minimum $35 ***Copay***/ Maximum $150 ***Copay***) *	Not Covered
Non-Formulary Brand Name	75% after Deductible (Minimum $70 ***Copay***/ Maximum $150 ***Copay***) *	Not Covered
Mail Order Pharmacy (90-day supply)		
Routine preventive drugs required by the ***Affordable Care Act***	100% Deductible Waived	Not Applicable
Generic	$10 ***Copay*** after Deductible	Not Covered
Formulary Brand Name	75% after Deductible (Minimum $80 ***Copay***) *	Not Covered
Non-Formulary Brand Name	75% after Deductible (Minimum $80 ***Copay***) *	Not Covered

PRESCRIPTION DRUG BENEFITS – TRADITIONAL PLAN	*Participating Pharmacies*	*Nonparticipating Pharmacies*
Specialty Drugs (30-day supply)		
Generic	85% after Deductible (Maximum $150 ***Copay***)	Not Covered
Formulary Brand Name	85% after Deductible (Maximum $150 ***Copay***) *	Not Covered
Non-Formulary Brand Name	85% after Deductible (Maximum $150 ***Copay***) *	Not Covered

* If the ***covered person*** selects a brand drug when a generic equivalent is available, the ***covered person*** is responsible for the brand ***copay*** plus the cost difference between the generic and brand equivalent. This difference may apply to the prescription deductible.

Refer to *Prescription Drug Program* for complete details.

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Medical Filing Procedure, Medical Expense Benefit, Medical Exclusions, Prescription Drug Program,* and *Plan Exclusions*.

Medical Benefits:

Benefit Period: January 1 – December 31

MEDICAL BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN	
Deductible *(per benefit period)*	
Individual	$4,000
Family (embedded)	$8,000
Generally, each ***covered person*** must pay all of the costs from providers up to the deductible amount before the ***Plan*** begins to pay. **Embedded Family Deductible**: Each ***covered person*** in the family must satisfy the individual embedded deductible until the family deductible has been satisfied, before this ***Plan*** begins to pay for ***covered expenses*** that are subject to the deductible.	
Out-of-Pocket Expense Limit (includes deductible and ***coinsurance***)	
Individual	$4,000
Family (embedded)	$8,000
The out-of-pocket expense limit is the most the ***covered person*** could pay in a year for covered services. **Embedded Family Out-of-Pocket Expense Limit:** Each ***covered person*** in the family must satisfy the individual embedded out-of-pocket expense limit until the family out-of-pocket expense limit has been satisfied. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.	
Standard *coinsurance* paid by the *Plan*	100%

MEDICAL BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN	***Facilities/Preferred Provider/Nonpreferred Provider*** (% of ***negotiated rate*** or ***allowable claim limit***, if applicable)
Allergy Services *(includes **physician** office visit and **urgent care center**)*	
Allergy injections	100% after Deductible
Allergy serum	100% after Deductible
Allergy testing	100% after Deductible
Ambulance	
Land	100% after Deductible
Air	100% after Deductible

MEDICAL BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN	***Facilities/Preferred Provider/Nonpreferred Provider*** (% of ***negotiated rate*** or ***allowable claim limit***, if applicable)
Applied Behavior Analysis Therapy (ABA)	Not Covered
Bereavement Counseling	100% after Deductible
Birthing Center	100% after Deductible
Blood *(Blood storage and transfusions)*	100% after Deductible
Cardiac Rehabilitation	
Facility	100% after Deductible
Physician	100% after Deductible
Chemotherapy	
Facility	100% after Deductible
Physician	100% after Deductible
Chiropractic Care Office visits, spinal manipulation, adjustments and x-rays	100% after Deductible Maximum: $500 per Benefit Period
Complementary/Alternative Medicine *(includes Acupuncture/Acupressure, Therapeutic Massage, Nutrition Therapy, Rolfing, and Naturopathy Care)*	100% after Deductible Maximum: $1,000 per Benefit Period
Contraceptives	See Women's Preventive Services
Diagnostic Services – Major *(such as MRI, CT Scan, PET Scan)*	100% after Deductible
Diagnostic Services – Minor	
X-rays	100% after Deductible
Laboratory services (including independent labs)	100% after Deductible
Other diagnostic services	100% after Deductible
Dialysis Therapy or Treatment	
Facility	100% after Deductible
Physician	100% after Deductible
Durable Medical Equipment	100% after Deductible
Emergency Services – (for an ***emergency***)	
Facility	100% after Deductible
Physician	100% after Deductible
Emergency Services – (not for an ***emergency***)	
Facility	100% after Deductible
Physician	100% after Deductible

MEDICAL BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN	***Facilities/Preferred Provider/Nonpreferred Provider*** (% of ***negotiated rate*** or ***allowable claim limit***, if applicable)
Hearing	
Routine Exam, Testing	100% after Deductible
Hearing Aids and Devices	100% after Deductible
Cochlear Implants	Not Covered
	Maximum: $4,500 per 5 Year Period
Home Health Care *(pre-certification required)*	
Home health care visits	100% after Deductible
Home health care supplies & services	100% after Deductible
IV therapy	100% after Deductible
	Maximum: 120 Visits per Benefit Period
Hospice Care	
Inpatient *(pre-certification required)*	100% after Deductible
Outpatient	100% after Deductible
Hospital – Inpatient *(pre-certification required)*	
Facility	100% after Deductible
Physician/Surgeon	100% after Deductible
Anesthesia, Radiology, Pathology, Lab	100% after Deductible
Hospital – Outpatient & Ambulatory Surgical Facility	
Facility	100% after Deductible
Physician/Surgeon	100% after Deductible
Anesthesia, Radiology, Pathology, Lab	100% after Deductible
Infertility Services	
Diagnostic testing to determine infertility	100% after Deductible
Surgical procedures to correct infertility	100% after Deductible
Medications and treatments	Not Covered
Infusion Therapy	
Facility	100% after Deductible
Physician	100% after Deductible
Injectables *(See Allergy Services for allergy shots)*	
Office visit	100% after Deductible
Outpatient	100% after Deductible

MEDICAL BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN	***Facilities/Preferred Provider/Nonpreferred Provider*** (% of ***negotiated rate*** or ***allowable claim limit***, if applicable)
Mental and Nervous Disorders and Substance Abuse	
Inpatient *(pre-certification required)*	100% after Deductible
Outpatient visit	100% after Deductible
Office Visits	
Gunnison County Family Physicians	100% after Deductible
Primary care physician	100% after Deductible
Specialist	100% after Deductible
Outpatient other services	100% after Deductible
Office Visit & Other Services	
Office Visit/Consultation	
Gunnison County Family Physicians	100% after Deductible
Primary care physician	100% after Deductible
Specialist	100% after Deductible
Injectables	100% after Deductible
Surgery	100% after Deductible
X-ray, lab, minor diagnostics	100% after Deductible
Other services	100% after Deductible
Orthotics	100% after Deductible
Podiatry Services	Based on Service Provided
Pregnancy	
Initial pre-natal visit and urinalysis	100% Deductible Waived
Subsequent pre-natal visits/care and breastfeeding services and supplies (as required by the ***Affordable Care Act***)	100% Deductible Waived
Post-natal care and other non-routine/non-preventive pregnancy related care.	Based on Service Provided
Delivery	100% after Deductible

MEDICAL BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN	***Facilities/Preferred Provider/Nonpreferred Provider*** (% of ***negotiated rate*** or ***allowable claim limit***, if applicable)
Prescription Drugs	
Retail Pharmacy	
Drugs dispensed from a ***nonparticipating pharmacy***	Not Covered
Routine preventive drugs required by the ***Affordable Care Act***	100% Deductible Waived
Generic	
30-day supply	100% after Deductible
60-day supply	100% after Deductible
90-day supply	100% after Deductible
Formulary Brand Name (30-day supply)	100% after Deductible *
Non-Formulary Brand Name (30-day supply)	100% after Deductible *
Mail Order Pharmacy (90-day supply)	
Drugs dispensed from a ***nonparticipating pharmacy***	Not Covered
Routine preventive drugs required by the ***Affordable Care Act***	100% Deductible Waived
Generic	100% after Deductible
Formulary Brand Name	100% after Deductible *
Non-Formulary Brand Name	100% after Deductible *
Specialty Drugs (30-day supply)	
Drugs dispensed from a ***nonparticipating pharmacy***	Not Covered
Generic	100% after Deductible
Formulary Brand Name	100% after Deductible *
Non-Formulary Brand Name	100% after Deductible *
* If the ***covered person*** selects a brand drug when a generic equivalent is available, the ***covered person*** is responsible for the brand ***copay*** plus the cost difference between the generic and brand equivalent. This difference may apply to the prescription deductible.	
Private Duty Nursing	
Inpatient	Not Covered
Outpatient	Not Covered
Prostate Examinations	100% Deductible Waived
Prostheses	100% after Deductible
Radiation Therapy	
Facility	100% after Deductible
Physician	100% after Deductible

MEDICAL BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN	***Facilities/Preferred Provider/Nonpreferred Provider*** (% of ***negotiated rate*** or ***allowable claim limit***, if applicable)
Respiratory Therapy ***Facility*** ***Physician***	 100% after Deductible 100% after Deductible
Retail Clinic	100% after Deductible
Routine Preventive Care/Wellness Benefits Includes all 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). For additional information visit: http://www.uspreventiveservicestaskforce.org	100% Deductible Waived
Skilled Nursing Facility *(pre-certification required)*	100% after Deductible Maximum: 120 Days per ***Confinement***
Sterilization Male Female	 100% after Deductible See Women's Preventive Services
Temporomandibular Joint Syndrome (TMJ) Treatment (Does not include orthodontia or dental appliances)	Based on Service Provided
Therapy Services *(physical, speech and occupational)* ***Facility*** ***Physician***	 100% after Deductible 100% after Deductible Maximum : 60 Visits each per Benefit Period for Physical, Occupational and Speech Therapy
Transplants (Organ or Tissue) *(pre-certification required)* ***Facility*** ***Physician*** Travel	 100% after Deductible 100% after Deductible 100% after Deductible
Urgent Care Facility Visit All other services	 100% Deductible Waived 100% Deductible Waived
Vision – Routine Services *(Routine vision services required by the **Affordable Care Act** shall be covered under the Routine Preventive Care benefit)*	Not Covered

MEDICAL BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN	***Facilities/Preferred Provider/Nonpreferred Provider*** (% of ***negotiated rate*** or ***allowable claim limit***, if applicable)
Weight Loss Services	
Treatment of obesity (other than ***morbid obesity***)	Not Covered
Treatment of ***morbid obesity***	
Surgical treatment	Based on Service Provided
Non-surgical treatment and programs	Based on Service Provided
Wigs	Not Covered
Women's Preventive Services As required by the ***Affordable Care Act***	100% Deductible Waived
All Other C*overed Expenses*	100% after Deductible

PRE-CERTIFICATION REQUIREMENTS
Inpatient Admissions (***hospital***, rehabilitation, ***skilled nursing facility***, transplant)
Partial Confinements
Home Health Care (including infusions)
Hospice Care
Transplants

PREFERRED PROVIDER OR NONPREFERRED PROVIDER

(Applies to ***professional providers*** only)

Covered persons have the choice of using either a ***preferred provider*** or a ***nonpreferred provider***.

PREFERRED PROVIDER

A ***preferred provider*** is a ***professional provider*** which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a ***negotiated rate*** for services rendered to ***covered persons***. In turn, the PPO has an agreement with the ***plan administrator*** or CoreSource to allow access to ***negotiated rates*** for services rendered to ***covered persons***. The PPO's name and/or logo is shown on the front of the ***covered person's*** ID card. The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate*** for ***covered expenses***. ***Covered persons*** should contact the ***employer's*** Human Resources Department, contact the CoreSource customer service department, or review the PPO's website for a current listing of ***preferred providers***.

NONPREFERRED PROVIDER

A ***nonpreferred provider*** does not have an agreement in effect with the ***Preferred Provider Organization***. The ***Plan*** will allow only the ***allowable claim limit*** as a ***covered expense***. The ***Plan*** will pay its percentage of the ***allowable claim limit*** for the ***nonpreferred provider covered expenses***.

Covered expenses for ***emergency services*** by a ***nonpreferred provider*** shall be paid at the greatest of the following three amounts: the amount negotiated with ***preferred providers*** for such ***covered expenses***, the amount determined as the ***customary and reasonable amount***, or the amount that would be paid under ***Medicare*** for such ***emergency services***.

For the purposes of the *Claim Review and Audit Program*, the ***Plan*** will allow only the ***allowable claim limit*** as a ***covered expense*** for ***facilities*** and ***nonpreferred providers***. Please refer to the *Claim Review and Audit Program* section of this document for additional information.

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 ***preferred providers*** in order to receive the ***preferred provider*** level of benefits.

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 ***Essential Health Benefits/***non-***Essential Health Benefits 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 ***negotiated rate*** for ***preferred providers,*** or the ***allowable claim limit*** in accordance with the *Claim Review and Audit Program* for ***hospitals, facilities*** and ***professional providers*** will not be considered a ***covered expense*** by the ***Plan***.

COPAY

The ***copay*** is the amount payable by the ***covered person*** for certain services, supplies or treatment. The service and applicable ***copay*** are shown on the *Schedule of Benefits*. The ***covered person*** selects a provider and pays the applicable ***copay***. The ***Plan*** pays the remaining ***covered expenses*** at the ***negotiated rate*** for ***preferred providers*** or the ***allowable claim limit*** for ***nonpreferred providers***. The ***copay*** must be paid each time a treatment or service is rendered.

The ***copay*** will not be applied toward the calendar year deductible.

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

If, in any calendar year, covered members of a family incur ***covered expenses*** that are subject to the deductible that are equal to or greater than the dollar amount of the family deductible shown on the *Schedule of Benefits*, then the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible.

COINSURANCE

The ***Plan*** pays a specified percentage of ***covered expenses*** at the ***allowable claim limit*** 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*** is applied to the out-of-pocket expense limit.

OUT-OF-POCKET EXPENSE LIMIT

Individual 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***, the ***Plan*** will begin to pay one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year.

Family Out-of-Pocket Expense Limit

If, in any calendar year, covered members of a family incurred an amount equal to the out-of-pocket expense limit listed on the *Schedule of Benefits*, then the family out-of-pocket expense limit will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family out-of-pocket expense limit, but no more than each person's individual out-of-pocket expense limit may be applied toward satisfaction of the family out-of-pocket expense limit.

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 the ***Plan***, including charges in excess of the ***negotiated rate*** for ***preferred providers*** or the ***allowable claim limit*** in accordance with the *Claim Review and Audit Program* for ***facilities*** and ***nonpreferred providers,*** as applicable.

2. For ***covered persons*** enrolled in the Traditional Plan, prescription drug expenses.

3. Expenses incurred as a result of a failure to obtain pre-certification.

MAXIMUM BENEFIT

The *Schedule of Benefits* may contain separate ***maximum benefit*** limitations for specified conditions and/or services. Any separate ***maximum benefit*** will include all such benefits paid by the ***Plan*** for the ***covered person*** during any and all periods of coverage under the ***Plan***. No more than the ***Essential Health Benefits/***non-***Essential Health Benefits maximum benefit*** will be paid for any ***covered person*** while covered by the ***Plan***.

Notwithstanding any provision of the ***Plan*** to the contrary, all benefits received by an individual under any benefit option, package or coverage under the ***Plan*** shall be applied toward the applicable ***maximum benefit*** paid by the ***Plan*** for any one ***covered person*** for such option, package or coverage under the ***Plan***, and also toward the ***maximum benefit*** under any other options, packages or coverages under the ***Plan*** in which the individual may participate in the future.

FACILITIES AND PROFESSIONAL PROVIDERS

Covered expenses for ***preferred providers*** are determined based on a percentage of the ***negotiated rate***. ***Covered expenses*** for ***facilities*** and ***nonpreferred providers*** will be determined under the ***Plan's*** *Claim Review and Audit Program*. Please refer to the section *Claim Review and Audit Program*, for additional information.

HOSPITAL/AMBULATORY SURGICAL FACILITY

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 Claim Filing Procedure* section of this document.

Covered expenses shall include the following and are subject to the ***allowable claim limit***:

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 ***room and board*** and for ***intensive care*** or cardiac care units shall be subject to the ***allowable claim limit*** for all ***hospitals*** and ***ambulatory surgical facilities***. 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***, including follow-up care provided within seventy-two (72) hours of a procedure.

4. Charges for pre-admission testing (x-rays and lab tests) performed prior to a ***hospital*** admission which are related to the condition which is necessitating the ***confinement***. Such tests shall be payable even if they result in additional medical treatment prior to ***confinement*** or if they show that ***hospital confinement*** is not ***medically necessary***. Such tests shall not be payable if the same tests are performed again after the ***covered person*** has been admitted.

AMBULANCE SERVICES

Covered expenses shall include:

1. Ambulance services for sea, 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. Transportation from the ***hospital*** to the patient's home is covered, if a home health care program is in place.

4. ***Emergency*** services actually provided by an advance life support unit, even though the unit does not provide transportation.

EMERGENCY SERVICES/EMERGENCY ROOM SERVICES

Covered expenses for ***emergency services*** in the emergency department of a ***hospital*** shall be paid in accordance with the *Schedule of Benefits*. ***Emergency services*** by a ***nonpreferred provider*** shall be paid as specified in the section, *Preferred Provider or Nonpreferred Provider*, under the subsection, *Nonpreferred Provider*.

Emergency room treatment for conditions that do not meet the definition of ***emergency*** will be considered non-***emergency*** use of the emergency room.

URGENT CARE FACILITY

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

PHYSICIAN SERVICES AND PROFESSIONAL PROVIDER SERVICES

Covered expenses shall include the following services when performed by a ***physician*** or a ***professional provider. Covered expenses*** are subject to the ***allowable claim limit*** for all ***nonpreferred providers*** and the percentage of the ***negotiated rate*** for all ***preferred providers***:

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*** from ***nonpreferred providers*** shall include the surgical allowance for the highest paying procedure, plus fifty percent (50%) of the surgical allowance for each additional procedure and ***covered expenses*** from ***preferred providers*** shall include the surgical allowance for the highest paying procedure plus fifty percent (50%) of the surgical allowance for the second highest paying 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 a ***nonpreferred*** assistant surgeon are limited to 13% - 16% of the surgical allowance, depending on the surgical assistance modifier. ***Covered expenses*** for the services of a ***preferred*** assistant surgeon are limited to 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.

The second surgical opinion benefit includes ***physician*** services only. Any diagnostic services will be payable under the standard provisions of the ***Plan***.

In the event a second surgical opinion is not recommended by the ***Health Care Management Organization*** or by the ***Plan***, the ***covered person*** may choose to seek an elective second surgical opinion; however, benefits will be paid as specified on the *Schedule of Benefits*.

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 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 the ***Plan***, the ***Plan*** will pay the recipient's ***covered expenses*** related to the transplant.

2. When the donor is covered under the ***Plan***, the ***Plan*** will pay the donor's ***covered expenses*** related to the transplant, provided the recipient is also covered under the ***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 the ***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 the ***Plan***. The donor's expenses shall be applied to the recipient's ***maximum benefit***. In no event will benefits for be payable in excess of the ***maximum benefit***.

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 the ***Plan***.

5. Transportation for the covered recipient and one (1) other person (two (2) other persons if the recipient is an eligible ***dependent*** child) to accompany the recipient to and from a ***facility***.

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.

Centers of Excellence Program

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

1-866-466-5053

A Center of Excellence is a ***facility*** within a Centers of Excellence Network that has been chosen for its proficiency in performing one or more transplant procedures. Usually located throughout the United States, the Centers 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 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***; when the fetus has a known condition incompatible with life, as determined by genetic counseling; or when the ***pregnancy*** is a result of rape or incest.

Complications from an abortion 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. ervices 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 male ***employee*** or covered male spouse. ***Covered expenses*** for elective surgical sterilization procedures for women shall be considered under the subsection, *Women's Preventive Services*. Reversal of surgical sterilization is not a ***covered expense***.

INFERTILITY SERVICES

Covered expenses shall include expenses for infertility testing and corrective surgical treatment 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, in-vitro fertilization, hormonal therapy, in-vivo fertilization or GIFT, embryo transfer, fertility drugs) will not be considered a ***covered expense***.

CONTRACEPTIVES

FDA approved contraceptive methods shall be considered under the subsection, *Women's Preventive Services*.

WELL NEWBORN CARE

The ***Plan*** shall cover well newborn care. ***Covered expenses*** for services, supplies or treatment of the newborn child shall be considered charges of the child and as such, subject to a separate deductible and ***coinsurance*** from the mother.

Such care shall include, but is not limited to:

1. ***Physician*** services

2. ***Hospital*** services

3. Circumcision

ROUTINE PREVENTIVE CARE/WELLNESS BENEFITS

Routine Preventive Care/Wellness Benefits 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. Annual routine mammograms.
3. Colonoscopies, including pre-procedure consultation, bowel preparation kits and pathology exam.

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 age seven (7) through eighteen (18) years and adults age 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.
6. Screening for tobacco use and two (2) tobacco cessation attempts per year and tobacco cessation medications for a ninety (90) day treatment regimen when prescribed by a ***physician.***
7. Prostate exam and Prostate Specific Antigen (PSA) tests and related testing.
8. Bone density testing.
9. Flu shots rendered at the County Health Department.

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.

The ***Plan*** will not provide coverage for the above referenced routine preventive care/wellness services, immunizations, screenings or supplies until the ***Plan*** year that begins on or after one year after the date such recommendation or guideline referenced above is issued.

Routine preventive care and wellness benefits are subject to the ***Essential Health Benefits maximum benefit*** as specified on the *Schedule of Benefits.*

WOMEN'S PREVENTIVE SERVICES

Covered expenses shall include the following preventive services recommended in guidelines issued by the U.S. Department of Health and Human Services' Health Resources and Services Administration:

1. Annual well-woman office visits to obtain preventive care;
2. Screening for gestational diabetes in a pregnant woman:
   a. Between twenty-four (24) and twenty-eight (28) weeks of gestation; and
   b. At the first prenatal visit for a pregnant woman identified to be at high risk for diabetes.
3. Human papillomavirus (HPV) DNA testing no more frequently than every three (3) years for a woman age thirty (30) and above;
4. Annual counseling for sexually transmitted infections for a sexually active woman;
5. Annual counseling and screening for human immune deficiency virus for a sexually active woman;
6. FDA approved contraceptive methods, sterilization procedures and patient education and counseling for a woman with reproductive capacity. ***Covered expenses*** shall include charges for medical procedures or supplies related to contraception, including the surgical implantation and removal of contraceptive devices.

   For ***covered persons*** enrolled in the Traditional plan, ***covered expenses*** include all FDA approved devices diaphragms, implants, injections, and IUD's. Other FDA contraceptives, including oral contraceptives and injectable contraceptives shall be covered under the *Prescription Drug Program* only.

   For ***covered persons*** enrolled in the High Deductible Health Plan, ***covered expenses*** include all FDA approved devices diaphragms, implants, injections, and IUD's. Other FDA contraceptives, including oral contraceptives and injectable contraceptives shall be covered under the subsection *Prescription Drugs.*
7. Breastfeeding support, supplies and counseling, to include the cost of rental or purchase, whichever is less costly, of breastfeeding equipment; and
8. Annual screening and counseling for interpersonal and domestic violence.
9. Genetic counseling for women identified to be at higher risk of having a potentially harmful gene mutation, and, if indicated, BRCA testing for harmful BRCA mutations.

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.

The ***Plan*** will not provide coverage for the above referenced women's preventive services until the ***Plan*** year that begins on or after one year after the date such recommendation or guideline referenced above is issued.

THERAPY SERVICES

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

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. Infusion therapy.

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

SKILLED NURSING FACILITY

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

Skilled nursing 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 ***skilled nursing facility***) limited to the ***facility's*** average ***semiprivate*** room rate; and

2. Other services, supplies and treatment ordered by a ***physician*** and furnished by the ***skilled nursing facility*** for ***inpatient*** medical care.

Skilled nursing facility benefits are subject to the ***Essential Health Benefits maximum benefit*** specified on the *Schedule of Benefits*.

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 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 ***skilled nursing 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;

4. Medical social service consultations;

5. Nutritional guidance by a registered dietitian and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary***.

Covered expenses shall be subject to the ***Essential Health Benefits maximum benefit*** specified on the *Schedule of Benefits*.

A visit by a member of a home health care team and four (4) hours of ***home health aide service*** will each be considered one (1) home health care visit.

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 provided in the patient's home is subject to pre-certification. Failure to obtain pre-certification shall result in a reduction of benefits as specified in the *Medical 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. Respite care by an aide who is employed by the ***hospice*** for up to five (5) consecutive days per month. (Respite care provides care of the ***covered person*** to allow temporary relief to family members or friends from the duties of caring for the ***covered person***).

8. Bereavement counseling as a supportive service to ***covered persons*** in the terminally ill ***covered person's*** immediate family. Benefits will be payable provided on the date immediately before death, the terminally ill person was covered under the ***Plan*** and receiving ***hospice*** care benefits.

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 the ***Plan***.

DURABLE MEDICAL EQUIPMENT

Rental or purchase, whichever is less costly (except as noted below for oxygen concentrators), 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 the ***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.

Ongoing rental charges for oxygen concentrators shall be a covered expense, provided the equipment is determined to be medically necessary for the treatment of chronic conditions or upon diagnosis of severe lung disease or other hypoxia related symptoms or findings.

Covered expenses for the rental of breastfeeding equipment shall be considered under the subsection, *Women's Preventive Services*.

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 the ***Plan*** is not covered. Repair or replacement of a prosthesis which is ***medically necessary*** due to a patient's growth or physiological change in the patient's condition or every three (3) years due to normal wear and tear will be considered a ***covered expense***.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device, including custom/molded foot orthotics, 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

DENTAL SERVICES

Covered expenses shall include repair to the jaw, mouth or face or repair/replacement of a dental appliance or sound natural teeth provided it is the result of an ***injury***. Treatment must be completed within one (1) year of the ***injury*** unless the healing process delays treatment. Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit.

Covered expenses shall include charges for oral surgery such as incision and drainage of abscess, excision of cyst, resection of benign tumor or soft tissue, sialolithotomy, closure of salivary fistula, extraction of impacted teeth, dental

surgery not specifically listed if it would be covered if the same type of procedure were performed on another part of the body.

NOTE: Dental procedures covered under a dental plan maintained by the ***employer*** are not covered under this ***Plan***. Any remaining charges will be the ***covered person's*** responsibility.

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, a medical need to utilize the ***facility*** or the patient is age five (5) and under, that prohibits performing the treatment safely in an office setting. For the purpose of this provision, "concurrent hazardous medical condition" shall include hemophilia, uncontrolled diabetes and hypertension.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Surgical and non-surgical treatment of temporomandibular joint dysfunction (TMJ) or myofascial pain syndrome shall be a ***covered expense***, but shall not include orthodontia or prosthetic devices even if prescribed by a ***physician*** or ***dentist***.

ORTHOGNATHIC DISORDERS

Surgical and non-surgical treatment of orthognathic disorders shall be a ***covered expense***, but shall not include orthodontia or prosthetic devices prescribed by a ***physician*** or ***dentist***.

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 stocking; surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

Covered expenses for diabetic supplies shall be considered under the subsection, *Prescription Drugs* for the High Deductible Health Plan or the *Prescription Drug Program* for the Traditional Plan.

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 and the surgery is performed within one (1) year of the ***illness*** or ***injury*** unless a medical reason delays treatment. ***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 which interferes with bodily functions and the surgery is performed within one (1) year of the ***illness*** or ***injury*** unless a medical reason delays treatment.

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

The ***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, including nipple and areola reconstruction and repigmentation; 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

The ***Plan*** will pay for ***medically necessary covered expenses*** for ***inpatient*** and ***outpatient*** treatment, services or supplies for the treatment of ***mental and nervous disorders***.

Covered expenses shall include:

1. ***Inpatient hospital confinement***;

2. Individual psychotherapy;

3. Group psychotherapy; and

4. Psychological testing.

CHEMICAL DEPENDENCY CARE

The ***Plan*** will pay for ***medically necessary covered expenses*** for the ***inpatient*** and ***outpatient*** treatment of ***chemical dependency*** in a ***hospital*** or ***treatment center*** by a ***physician*** or ***professional provider***.

PRESCRIPTION DRUGS

The benefits in the subsection below apply to ***covered persons*** enrolled in the High Deductible Health Plan only. For ***covered persons*** enrolled in the Traditional Plan, prescription drugs shall be covered under the *Prescription Drug Program* section only.

Pharmacy Option

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

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

If a drug is purchased from a ***nonparticipating pharmacy*** there is no benefit.

If the ***covered person*** purchases a brand name drug when a ***generic drug*** is available, the ***covered person*** will be required to pay the difference between the ***generic drug*** and the brand name requested. This difference may apply to the deductible. The ***covered person*** may appeal the adverse benefit determination. Refer to the sub-section, *Appealing a Denied Post-Service Prescription Drug Claim,* for detailed information on how to initiate the appeal process.

When the out-of-pocket expense limit is reached, prescription drugs will be paid at 100%.

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.).

Any one prescription is limited to a ninety (90) day supply.

If the ***covered person*** purchases a brand name drug when a ***generic drug*** is available, the ***covered person*** will be required to pay the difference between the ***generic drug*** and the brand name requested. This difference may apply to the deductible. The ***covered person*** may appeal the adverse benefit determination. Refer to the sub-section, *Appealing a Denied Post-Service Prescription Drug Claim,* for detailed information on how to initiate the appeal process.

When the out-of-pocket expense limit is reached, prescription drugs will be paid at 100%.

Covered Prescription Drugs

1. Drugs prescribed by a ***physician*** that require a prescription either by federal or state law, except injectables (other than insulin and bee sting) and 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 meters.
4. Oral contraceptives, injectable contraceptives and contraceptive patches.
5. Legend pre-natal vitamins.
6. Retin-A for covered persons under age thirty-five (35).
7. Acne treatments. Accutane subject to prior authorization with letter of ***medical necessity***.
8. HIV/AIDS related medications.
9. Immunosupressants.
10. Injectable bee sting/Ana kits.
11. Migraine medications (Imitrex) limited to the following:

Nasal Sprays	Six sprays (one bottle)	every 22 days
Injections	Four injections (two kits)	every 22 days
Oral Pills	Nine pills (six for Maxalt)	every 22 days

12. Routine preventive drugs as required by the ***Affordable Care Act***.
13. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a ***qualified prescriber***.

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 or routine preventive drugs as required by the ***Affordable Care Act***.
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, injectables or any prescription directing administration by injection (other than insulin or bee sting).

11. A charge for prescription drugs for smoking cessation purposes, including smoking deterrent patches, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

12. A charge for infertility medication.

13. A charge for contraceptive devices.

14. A charge for legend vitamins, except pre-natal legend vitamins.

15. A charge for minerals.

16. A charge for fluoride supplements, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

17. A charge for medications that are cosmetic in nature (*i.e.*, treating hair loss, wrinkles, etc.).

18. A charge for growth hormones.

19. A charge for weight loss drugs (unless for weight control of prior authorization documented cases where the patient is one hundred (100) or more pounds overweight).

20. A charge for Levonorgestrel (Norplant implants).

21. A charge for Hematinics.

22. A charge for drugs used in the treatment of erectile dysfunction (*i.e.*, Viagra).

23. A charge for non-legend drugs, other than as specifically listed herein or as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

Specialty Drugs

The CVS Caremark Specialty Pharmacy is available for certain medications related to the conditions or treatment programs listed below. The ***Plan*** has elected to work with CVS Caremark Specialty Pharmacy to enhance and assist in the management of these specialty medications. Services include enhanced customer service and substantial discounts through volume discount manufacturer pricing. These discounts may reduce the patient's cost.

To receive these specialty drugs, the patient should provide a copy of the identification card to the ***physician***. The ***physician*** will submit the prescription.

Asthma	Hemophilia	Osteoarthritis/Rheumatoid Arthritis
Chronic Renal	Hepatitis	Pain Management
Crohn's Disease	Immune Therapy	Parkinson's
Endocrinology	IVIG	Psoriasis
Fabry's Disease	Multiple Sclerosis	Pulmonary
Fertility	Neurology	Pulmonary Fibrosis
Gaucher's Disease	Oncology	Pulmonary Hypertension
Growth Hormone	Oncology Adjunct	Rabies
Hematology/Cardiology	Ophthalmology	Other Disorders

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

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of a denied claim by making written request to the ***claims processor*** 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*** for a full and fair review:

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. The period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
    a. The date the ***covered person*** responds to the new or additional rationale or evidence; or
    b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the ***covered person***.
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 ***claims processor*** will not afford deference to the original denial.
6. The ***claims processor*** 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 ***claims processor*** 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 ***claims processor*** 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 ***claims processor*** 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. 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.
6. 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.

ROUTINE PATIENT COSTS FOR APPROVED CLINICAL TRIALS

Covered expenses shall include charges for "routine patient costs" incurred by a "qualified individual" participating in an ***approved clinical trial.*** "Routine patient costs" do not include:

1. An investigational item, device or service;

2. An item or service provided solely to satisfy data collection and analysis needs, which are not used in the direct clinical management of the patient; or,

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"Life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Qualified Individual" means a ***covered person*** who is eligible to participate in an ***approved clinical trial*** according to the trial protocol with respect to the treatment of cancer or another "life-threatening disease or condition" and either;

1. The referring health care professional is a participating health care ***provider*** and has concluded that the ***covered person's*** participation in such trial would be appropriate; or,

2. The ***covered person*** provides medical and scientific information establishing that the **covered person's** participation in such trial would be appropriate.

"Routine patient costs" include all items and services consistent with the coverage provide by the ***Plan*** that is typically covered for a c***overed person*** who is not enrolled in a clinical trial.

OFF-LABEL DRUG USE

Covered expenses shall include charges for the use of an FDA-approved drug for a purpose other than that for which it is approved, but only when the drug is not excluded by the ***Plan*** and the ***plan sponsor*** determines in its sole discretion that the drug is appropriate and generally accepted for the condition being treated.

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.

HEARING BENEFIT

Services of a licensed audiologist to determine and measure hearing loss and hearing aids shall be a ***covered expense***, subject to the non-***Essential Health Benefits maximum benefit*** as specified on the *Schedule of Benefits*.

COMPLEMENTARY/ALTERNATVE MEDICINE

Covered expenses include naturopathy care, acupuncture, acupressure, nutrition therapy, Rolfing and therapeutic massage, subject to the non-***Essential Health Benefits maximum benefit*** as specified on the *Schedule of Benefits*.

CHIROPRACTIC CARE

Covered expenses include initial consultation, x-rays and treatment (including maintenance care), subject to the non-***Essential Health Benefits 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 and ostomy care. ***Covered expenses*** for patient education for contraception or lactation training shall be considered under the subsection, *Women's Preventive Services*.

SURCHARGES

Any surcharge or assessment (by whatever name called) on ***covered expenses***, required by state or federal law to be paid by the ***Plan*** for services, supplies and/or treatments rendered by a health care provider shall be a ***covered expense*** subject to the ***covered person's*** obligations under the ***Plan***.

OUTPATIENT CARDIAC/PULMONARY REHABILITATION PROGRAMS

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

Covered expenses shall include Phase 1 and Phase 2 cardiac rehabilitation for those patients with certain cardiac conditions who would materially benefit from cardiovascular exercise, and who are unable to engage in unsupervised exercise without a clear risk of an acute cardiac event. Cardiac rehabilitation should be initiated as soon after the cardiac event as it is safe to begin, depending on the condition, typically no more than 6-12 months after a surgery or procedure is performed. Services must be provided by a ***Medicare*** approved facility in accordance with ***Medicare*** guidelines.

SURGICAL AND NON-SURGICAL TREATMENT OF MORBID OBESITY

Any expenses, whether surgical, non-surgical, or therapeutic (including prescription drugs) that are related to weight management or the treatment of obesity will not be covered under the ***Plan*** regardless of the existence of any co-morbid conditions or psychological condition, unless the patient is ***morbidly obese*** as defined.

Covered expenses shall include charges for surgical treatment of ***morbid obesity*** for ***covered persons*** with health problems that are aggravated by or related to the ***morbid obesity***, including, but not limited to gastric by-pass, gastric stapling or gastric balloon. All expenses related to the treatment of ***morbid obesity*** that are otherwise payable under the ***Plan*** will be considered allowable expenses (e.g., surgery, hospitalization, anesthesia, office visits for a ***physician***, lab testing, psychotherapy, etc.). Services will be payable as described in each respective section.

Additionally, the ***Plan*** will review patient history for optimal candidacy for any proposed surgical treatment according to current, generally accepted medical practices. For example, this review will consider whether the patient has been

unable to lose weight through non-surgical, conventional measures and whether the individual's ability to manage the surgical intervention and required post-operative care has been assessed through a psychological evaluation. Unsuccessful weight loss attempts and lifestyle changes should be documented by medical office progress notes.

Other limitations include:

1. Appendectomies and cholecystectomies in conjunction with surgical treatment of ***morbid obesity*** will be considered incidental and not covered unless the individual has an existing condition that requires the additional surgical treatment.
2. Subsequent panniculectomy (surgery to remove loose skin) resulting from weight loss will be covered only if it is ***medically necessary*** as a result a documented history of treatment by a ***physician*** for skin related ***illnesses*** for a minimum of six (6) months where the treated condition is no longer controlled through any other means.

SLEEP DISORDERS

Covered expenses shall include charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.

ONCOLOGY MANAGEMENT PROGRAM

The purpose of the oncology management program (Program) is to assist the ***covered person*** and the ***covered person's*** oncologist during the ***covered person's*** course of cancer treatment when administered in either an ***outpatient*** setting (e.g. in the ***physician's*** office or other covered ***outpatient*** setting) or an ***inpatient*** setting. The Program only applies to the chemotherapy and radiation plans of treatment used in connection with the ***covered person's*** cancer treatment.

In order to initiate the oncology management process, the ***covered person*** should contact CoreSource to verify ***Plan*** benefits; however, such verification is not a guarantee of benefits. CoreSource will contact the vendor of the Program to discuss the plan of treatment and if appropriate initiate the Program upon receipt of the initial claim for benefits.

Once CoreSource has contacted the Program vendor, a certified oncology nurse or Oncology Case Manager (OCM) will be assigned to the ***covered person's*** case. The OCM will contact the ***covered person*** periodically to provide support, education, and answer any questions from the ***covered person***. At the same time, the OCM will contact the oncologist to discuss the proposed plan of treatment and assist in coordinating the information pertaining to the various cycles of the plan of treatment.

If the ***covered person's*** oncologist determines that oral anti-cancer drugs and/or supportive medications should be taken in the home setting following the chemotherapy treatment received on an ***inpatient*** or ***outpatient*** basis, the oncologist may require that the drugs be sent to the ***covered person's*** home in time to meet the medication schedule specified by the oncologist.

In order to receive benefit payments under the ***Plan***, the oncologist's plan of treatment must be received by the Program vendor, and determined by CoreSource not to be experimental and/or investigative. If any of the drugs prescribed by your oncologist require specific pathology results or molecular marker results to validate their use, these results must be provided to the Program vendor prior to validation of your treatment regimen.

The ***Plan*** will not pay for or otherwise cover the cost of drugs considered experimental and/or investigative by CoreSource.

Notwithstanding the ***Plan's*** definition and exclusions of ***experimental/investigative***, in the context of drugs used in the treatment of cancer, the use of a drug will not be considered ***experimental/investigative*** if:

1. the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs and Biologics Compendium, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints or Clinical Pharmacology; or

2. the drug is provided in association with a Phase III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute (NCI); or

3. the drug is provided in association with a Phase II trial for cancer by an NCI-sponsored group and standard treatment has been or would be ineffective or does not exist or there is no clearly superior non-investigational alternative that can be delivered more cost efficiently as determined by CoreSource.

Covered expenses from ***facilities*** and ***nonpreferred providers*** shall include the following and are subject to the ***allowable claim limit***:

CLAIM REVIEW AND AUDIT PROGRAM

The ***Plan*** has arranged with the ***Designated Decision Maker*** **(*DDM*)** for a program of claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services which are not medically appropriate. Benefits for ***facility*** and ***nonpreferred provider*** claims which are selected for review and auditing will be reduced for any charges that are determined to be in excess of ***allowable claim limits*** (as defined below). The determination of ***allowable claim limits*** under this Program will supersede any ***Plan*** provisions related to application of a usual, customary and reasonable fee determination.

Facilities and ***nonpreferred providers*** will be given a fully detailed explanation of any charges that are found to be in excess of ***allowable claim limits***, and allowed the rights and privileges to file an appeal of the determination which are the same rights and privileges accorded to ***covered persons***; and, in return, the ***facility*** and ***nonpreferred provider*** must agree not to bill the claimant for charges which were not covered as a result of the claim review and audit. This will in no way affect the rights of the claimant to file an appeal under the ***Plan.*** Please refer to the subsections, *Provider of Service Appeal Rights – Claim Review and Audit Program* and *Appealing a Denied Post-Service Claim* for procedures for claims and appeals for additional information regarding claimant and provider appeals.

In the event that a ***covered person*** receives a balance-due billing from a ***facility*** or ***nonpreferred provider*** for charges in excess of the ***allowable claim limit***, the ***covered person*** should contact ***claims processor*** at the number shown on their ID card for assistance.

The claimant must pay for any normal cost-sharing features of the ***Plan***, such as deductibles, coinsurance and copayments, and any amounts otherwise excluded or limited according to the terms of the ***Plan***.

The success of this Program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the ***Plan*** will be unable to make a determination of the amount of ***covered expense*** that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the provider of service and the ***covered person***. In the event that the ***Plan Administrator*** does not receive information adequate for the claim review and audit within the time limits required under applicable law, it will be necessary to deny the claim. Should such a denial be necessary, the ***Plan*** participant and/or the ***facility*** or ***nonpreferred provider*** may appeal the denial in accordance with the provisions which may be found in the section for claim appeals in subsections, *Provider of Service Appeal Rights – Claim Review and Audit Program* and *Appealing a Denied Post-Service Claim.*

Allowable claim limits means the charges for services and supplies, listed and included as ***covered expenses*** from a ***facility*** or ***nonpreferred provider*** under the ***Plan***, which are ***medically necessary*** for the care and treatment of ***illness*** or ***injury***, but only to the extent that such fees are within the ***allowable claim limits***. Determination that a charge is within the ***allowable claim limit*** will be made by the ***DDM*** and will include, but not be limited to, the following guidelines:

1. **Errors, Unbundled and/or Unsubstantiated Charges**. ***Allowable claim limits*** will not include the following amounts:

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

2. **Guidelines.** The following guidelines will be used when determining ***allowable claim limits***:

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

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

c. **Nonpreferred Professional Providers.** The ***allowable claim limits*** for ***nonpreferred professional providers*** shall be determined using the following:

   i. For general ***nonpreferred professional provider*** medical and primary care claims, the ***Medicare*** allowed amount in the geographic area plus an additional 40%;

   ii. For specialist medical and surgical care claims, the ***Medicare*** allowed amount in the geographic area plus an additional 55%;

   iii. For anesthesiologist claims, the ***Medicare*** allowed amount in the geographic area plus an additional 100%;

   iv. For all other ***nonpreferred professional provider*** claims and supplies (such as ***durable medical equipment***, laboratory services and supplies, ambulance, air ambulance, etc.), the ***Medicare*** allowed amount in the geographic area plus an additional 25%.

   For purposes of determining the proper ***allowable claims limits*** for ***nonpreferred professional providers*** in categories (i), (ii), (iii) or (iv), above, the ***DDM*** shall determine the applicable category for each claim based on the taxonomy code used by the ***nonpreferred professional provider*** for that claim. The ***DDM*** determines in its sole discretion the type of provider for determining ***allowable claim limits***, as detailed above.

d. **Directly Contracted Providers.** The ***allowable claim limits*** for ***facilities*** and ***nonpreferred providers*** who are contracted with the ***DDM*** will be the rate under the ***direct agreement***.

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

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

   ii. **Pharmaceuticals.** The ***allowable claim limit*** for pharmacy charges by a ***facility*** or ***nonpreferred provider*** may be determined by applying the Average Wholesale Price (AWP) as defined by REDBOOK at the rate of 112% of AWP.

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

iv. **Physician, Medical and Surgical Care, Laboratory, X-ray, and Therapy.** The ***allowable claim limit*** for these services may be determined based upon the 60th percentile of Fair Health (FH®) Allowed Benchmarks.

Comparable Services or Supplies. In the event that insufficient information is available to determine ***allowable claim limits*** for specific services or supplies using the guidelines listed in Section 2 above, ***allowable claim limits*** will be determined considering the most comparable services or supplies based upon comparative severity and/or geographic area to determine the allowable claim limit. The ***DDM*** reserves the right, in its sole discretion, to determine any ***allowable claim limit*** amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any ***covered person***.

In the event that a determination of ***allowable claim limit*** for a claim exceeds the actual charges billed for the services and/or supplies, the actual charges billed for the claim shall be the ***allowable claim limit***.

PROVIDER OF SERVICE APPEAL RIGHTS – CLAIM REVIEW AND AUDIT PROGRAM

A ***covered person*** may appoint the ***facility*** or ***nonpreferred provider*** as the authorized representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a ***covered person*** to a ***facility*** or ***nonpreferred provider*** will not constitute appointment of that ***facility*** or ***nonpreferred provider*** as an authorized representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a ***facility*** and ***nonpreferred provider*** that is not an authorized representative, the ***Plan*** will consider an appeal received from the ***facility*** or ***nonpreferred provider*** in the same manner as a ***covered person's*** appeal, and will respond to the ***facility*** or ***nonpreferred provider*** and the ***covered person*** with the results of the review accordingly. Any such appeal from a ***facility*** or ***nonpreferred provider*** must be made within the time limits and under the conditions for filing an appeal specified under the sub-section, *Appealing a Denied Post-Service Claim*. ***Facilities* or *nonpreferred providers* requesting such appeal rights under the *Plan* must agree to pursue reimbursement for *covered expenses* directly from the *Plan*, waiving any right to recover such expenses from the *covered person*, and comply with the conditions of the sub-section,** *Appealing a Denied Post-Service Claim***.**

For purposes of this section, the ***facility*** or ***nonpreferred provider's*** waiver to pursue ***covered expenses*** does not include the following amounts, which are the responsibility of the ***covered person***:

- Deductibles;
- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the ***Plan***;
- Charges for services and supplies which are not included for coverage under the ***Plan,*** and
- Amounts which are in excess of any stated ***Plan*** maximums or limits. **Note: this does <u>not</u> apply to amounts found to be in excess of *allowable claim limits*, as defined in the section,** *Claim Review and Audit Program***.** The ***facility*** or ***nonpreferred provider*** must agree to waive its right to balance bill for any amounts found to be in excess of ***allowable claim limits***.

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

Contact the ***claims processor*** or the ***Plan Administrator*** for additional information regarding provider of service appeals.

ONLINE PAYMENT MANAGER

Claim processor offers the CoreSource Online Payment Manager service that enables eligible ***covered persons*** to pay their out-of-pocket obligations directly to providers.

RELAY SERVICES

Relay Network, LLC provides telephonic messaging, including text messaging, to ***covered persons*** who opt into the service. Such messaging shall include, but not be limited to, information about services and benefits available under the ***Plan***, reminders on preventive care, surveys, and educational information.

MEDICAL EXCLUSIONS

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

1. Charges for services, supplies or treatment for the reversal of surgical sterilization procedures and sterilization of a male ***dependent*** child.

2. 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, fertility drugs, embryo implantation, or gamete intrafallopian transfer (GIFT), other than services to diagnose the cause of infertility and surgical procedures to correct infertility.

3. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

4. Charges for treatment or surgery for sexual dysfunction or inadequacies.

5. Charges for ***hospital*** admission on Friday, Saturday or Sunday unless the admission is an ***emergency*** situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, ***hospital*** expenses will be payable commencing on the date of actual surgery.

6. Charges for ***inpatient room and board*** in connection with a ***hospital confinement*** primarily for diagnostic tests, unless it is determined by the ***Plan*** that ***inpatient*** care is ***medically necessary***.

7. Charges for services, supplies or treatment for behavior or conduct disorders, learning disorders, or senile deterioration. However, the initial examination, office visit and diagnostic testing to determine the ***illness*** shall be a ***covered expense***.

8. Charges for biofeedback therapy.

9. Except as specified herein, charges for services, supplies or treatments which are primarily educational in nature, charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

10. Charges for marriage, family, career, pastoral counseling, funeral arrangements, or 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; dental implants or dental appliances such as dental guards, dentures, orthodontic braces and similar appliances.

12. Charges for routine vision examinations and eye refractions; vision therapy (orthoptics); eyeglasses or contact lenses, except as specified herein; dispensing optician's services.

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 except as provided in, *Routine Preventive Care/Wellness Benefits* United States Preventive Services Task Force (USPSTF) recommendations and for the High Deductible Health Plan provided in *Prescription Drugs*.

17. For the High Deductible Health Plan, any prescription refilled in excess of the number specified by the ***physician*** or any refill dispensed after one (1) year from the ***physician's*** original order.

18. For the High Deductible Health Plan, charges for ***outpatient*** prescription drugs, except as specifically indicated in *Medical Expense Benefit, Prescription Drugs*.

19. For the Traditional Plan, charges for prescription drugs that are covered under the *Prescription Drug Program* or for the Prescription Drug deductible or ***copay*** applicable thereto. ***Outpatient*** prescription drugs are paid under the *Prescription Drug Program* and under no other provision of the ***Plan***.

20. 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.

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

22. Charges ***incurred*** as a result of, or in connection with, any procedure or treatment excluded by the ***Plan*** which has resulted in medical complications, except for complications from a non-covered abortion as specified herein.

23. 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***.

24. 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 or as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

25. Charges for surgical weight reduction procedures and all related charges, unless resulting from ***morbid obesity***.

26. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

27. Charges for a cochlear implant or bone-anchored hearing aid, auditory brainstem implant, or any other surgically implantable device to correct hearing loss, or surgery to implant such a device.

28. Charges for services required by a third party, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

29. Except as specifically stated in *Medical Expense Benefit, Temporomandibular Joint Dysfunction*, charges for treatment of temporomandibular joint dysfunction and myofascial pain syndrome including, but not limited to: charges for treatment to alter vertical dimension or to restore abraded dentition, orthodontia and intra-oral orthotic or prosthetic devices.

30. Charges for ***custodial care***, domiciliary care or rest cures.

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

32. Charges for wigs, artificial hairpieces, artificial hair transplants, or any drug - prescription or otherwise -used to eliminate baldness or stimulate hair growth.

33. Charges for expenses related to hypnosis.

34. Charges for the expenses of the donor of an organ or tissue for transplant to a recipient who is not a ***covered person*** under the ***Plan***.

35. 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.

36. Charges for environmental change including ***hospital*** or ***physician*** charges connected with prescribing an environmental change.

37. Charges for ***room and board*** in a ***facility*** for days on which the ***covered person*** is permitted to leave (a weekend pass, for example).

38. Charges for chelation therapy, except as treatment of heavy metal poisoning.

39. Charges for sex therapy, diversional therapy or recreational therapy.

40. Charges for procurement and storage of one's own blood, unless ***incurred*** within three (3) months prior to a scheduled surgery.

41. Charges for holistic or homeopathic care, including drugs and herbal medicines.

42. Charges for or related to the following types of treatment:
    a. primal therapy;
    b. psychodrama;
    c. visual perceptual training;
    d. hair analysis;
    e. recreational, music or remedial reading therapy.

43. Charges for structural changes to a house or vehicle.

44. Charges for exercise programs for treatment of any condition.

45. Charges for immunizations required for travel.

46. Charges for drugs, devices, supplies, treatments, procedures or services that are considered ***experimental/investigational*** by the ***Plan***. The ***Plan*** will consider a drug, device, supply, treatment, procedure or service to be "***experimental***" or "***investigational***":

    a. if, in the case of a device or supply, the device or supply 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 device or supply is furnished; or

b. if the drug, device, supply, treatment, procedure or service, or the patient's informed consent document utilized with respect to the drug, device, supply, treatment, procedure or service was reviewed and approved by the treating ***facility's*** institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

c. if the ***plan sponsor*** (or its designee) determines in its sole discretion that the drug, device, supply, treatment, procedure or service is the subject of on-going Phase I or Phase II clinical trials; is the research, ***experimental*** study or ***investigational*** arm of on-going Phase III clinical trials, or is otherwise under study to determine maximum tolerated dose, toxicity, safety or efficacy, however, a drug that meets the standards set in the section *Medical Expense Benefit, Off-Label Drug Use* will not be deemed ***experimental*** or ***investigational*** solely by reason of this subparagraph; or

d. if the ***plan sponsor*** (or its designee) determines in its sole discretion based on documentation in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature that the prevailing opinion among experts regarding the drug, device, supply, treatment, procedure or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy.

47. Adoption expenses.

48. Amniocentesis to determine the gender of the newborn or in the absence of known risk factors including but not limited to, maternal age, previous child with chromosomal disorder, abnormal ultrasound, or family history or other documented risk of a detectable, single gene disorder.

49. Services rendered which are eligible for payment or coverage by any other plan that does not provide coordination of benefits.

50. Duplicate tests by different ***physicians***, except when ***medically necessary*** to monitor a patient's medical condition.

51. Fetal surgery and related charges when the procedure is ***experimental*** or not performed to enhance or protect the outcome of the pregnancy.

52. Home testing kits.

53. Homemaker or housekeeping services.

54. Charges went there has been an incomplete claim submission.

55. Charges for late discharge or late check-out if the discharge results from convenience.

56. Charges for legal expenses or fees incurred in obtaining medical treatment or payment of claims.

57. Charges for 23-hour outpatient observation care in excess of the cost of one day care at the ***hospital's*** semiprivate room rate.

58. Charges for paternity testing.

59. Private duty nursing.

60. Shock therapy.

61. Charges for a standby physician, except when required because of a ***hospital*** policy or state law or ordered by the delivering ***physician*** or surgeon.

62. Charges for thermography, thermogram, or thermoscribe.

63. Charges for vitamin injections, unless the injections are for a diagnosed medical condition or when substitution with over-the-counter medication would endanger the patient's well-being.

64. Charges for any services, supplies or treatment not specifically provided herein.

PRESCRIPTION DRUG PROGRAM

The benefits in this section apply to ***covered persons*** enrolled in the Traditional Plan only. For ***covered persons*** enrolled in the High Deductible Health Plan, prescription drugs shall be covered under the Medical Expense Benefit, *Prescription Drugs* section only.

PRESCRIPTION DRUG DEDUCTIBLE

Individual Deductible

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

The medical deductible is calculated separately from the prescription deductible.

PRESCRIPTION DRUG OUT-OF-POCKET EXPENSE LIMIT

Individual Drug Out-of-Pocket Expense Limit

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

Family Drug Out-of-Pocket Expense Limit

If, in any calendar year, covered members of a family incurred an amount equal to the out-of-pocket expense limit listed on the *Schedule of Benefits*, then the family drug out-of-pocket expense limit will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family drug out-of-pocket expense limit, but no more than each person's individual drug out-of-pocket expense limit may be applied toward satisfaction of the family drug out-of-pocket expense limit.

Out-of-Pocket Expense Limit Exclusions

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

1. Expenses for services, supplies and treatments not covered by the ***Plan***, including charges in excess of the ***negotiated rate*** for covered prescription drugs.

2. Drugs dispensed by a ***nonparticipating pharmacy***.

3. Medical expenses. The medical out-of-pocket expense limit is calculated separately from the prescription drug out-of-pocket expense limit.

PHARMACY OPTION

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

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*.

The ***Plan*** will pay the designated percentage of ***covered expenses*** and will apply the applicable ***copay*** after the prescription drug deductible until the prescription drug out-of-pocket expense limits are reached.

If a drug is purchased from 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.

If a drug is purchased from a ***nonparticipating pharmacy*** there is no benefit.

If the ***covered person*** purchases a brand name drug when a ***generic drug*** is available, the ***covered person*** will be required to pay the difference between the ***generic drug*** and the brand name requested, plus the brand ***copay***. This difference may apply to the prescription deductible. The ***covered person*** may appeal the adverse benefit determination. Refer to the sub-section, *Appealing a Denied Post-Service Prescription Drug Claim,* for detailed information on how to initiate the appeal process.

When the prescription drug out-of-pocket expense limit is reached, prescription drugs will be paid at 100%.

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.).

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.

If the ***covered person*** purchases a brand name drug when a ***generic drug*** is available, the ***covered person*** will be required to pay the difference between the ***generic drug*** and the brand name requested, plus the brand ***copay***. This difference may apply to the prescription deductible. The ***covered person*** may appeal the adverse benefit determination. Refer to the sub-section, *Appealing a Denied Post-Service Prescription Drug Claim,* for detailed information on how to initiate the appeal process.

When the prescription drug out-of-pocket expense limit is reached, prescription drugs will be paid at 100%.

COVERED PRESCRIPTION DRUGS

1. Drugs prescribed by a ***physician*** that require a prescription either by federal or state law, except injectables (other than insulin and bee sting) and 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 meters.
4. Oral contraceptives, injectable contraceptives and contraceptive patches.
5. Legend pre-natal vitamins.
6. Retin-A for covered persons under age thirty-five (35).
7. Acne treatments. Accutane subject to prior authorization with letter of ***medical necessity***.
8. HIV/AIDS related medications.
9. Immunosupressants.
10. Injectable bee sting/Ana kits.
11. Migraine medications (Imitrex) limited to the following:

Nasal Sprays	Six sprays (one bottle)	every 22 days
Injections	Four injections (two kits)	every 22 days
Oral Pills	Nine pills (six for Maxalt)	every 22 days

12. Routine preventive drugs as required by the ***Affordable Care Act***.
13. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a ***qualified prescriber***.

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 or routine preventive drugs as required by the ***Affordable Care Act***.

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, injectables or any prescription directing administration by injection (other than insulin or bee sting).

11. A charge for prescription drugs for smoking cessation purposes, including smoking deterrent patches, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

12. A charge for infertility medication.

13. A charge for contraceptive devices.

14. A charge for legend vitamins, except pre-natal legend vitamins.

15. A charge for minerals.

16. A charge for fluoride supplements, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

17. A charge for medications that are cosmetic in nature (*i.e.*, treating hair loss, wrinkles, etc.).

18. A charge for growth hormones.

19. A charge for weight loss drugs (unless for weight control of prior authorization documented cases where the patient is one hundred (100) or more pounds overweight).

20. A charge for Levonorgestrel (Norplant implants).

21. A charge for Hematinics.

22. A charge for drugs used in the treatment of erectile dysfunction (*i.e.*, Viagra).

23. A charge for non-legend drugs, other than as specifically listed herein or as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

SPECIALTY DRUGS

The CVS Caremark Specialty Pharmacy is available for certain medications related to the conditions or treatment programs listed below. The ***Plan*** has elected to work with CVS Caremark Specialty Pharmacy to enhance and assist in the management of these specialty medications. Services include enhanced customer service and substantial discounts through volume discount manufacturer pricing. These discounts may reduce the patient's cost.

To receive these specialty drugs, the patient should provide a copy of the identification card to the ***physician***. The ***physician*** will submit the prescription.

Asthma
Chronic Renal
Crohn's Disease
Endocrinology
Fabry's Disease
Fertility
Gaucher's Disease
Growth Hormone
Hematology/Cardiology
Hemophilia
Hepatitis
Immune Therapy
IVIG
Multiple Sclerosis
Neurology
Oncology
Oncology Adjunct
Ophthalmology
Osteoarthritis/Rheumatoid Arthritis
Pain Management
Parkinson's
Psoriasis
Pulmonary
Pulmonary Fibrosis
Pulmonary Hypertension
Rabies
Other Disorders

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

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of a denied claim by making written request to the ***claims processor*** 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*** for a full and fair review:

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. The period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
   a. The date the ***covered person*** responds to the new or additional rationale or evidence; or
   b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the ***covered person***.
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 ***claims processor*** will not afford deference to the original denial.
6. The ***claims processor*** 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 ***claims processor*** 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 ***claims processor*** 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 ***claims processor*** 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. 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.
6. 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 appeal if the claim determination involves medical judgment or a rescission by making written request to the ***claims processor*** within four (4) months of receipt of notification of the final internal denial of benefits. Medical judgment includes, but is not limited to:

1. ***Medical necessity***;
2. Appropriateness;
3. ***Experimental*** or ***investigational*** treatment;
4. Health care setting;
5. Level of care; and
6. Effectiveness of a ***covered expense***.

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 1st falls on a Saturday, Sunday or Federal holiday.*}

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 the final internal denial was the result of:

1. Medical judgment; or
2. Rescission of coverage under this ***Plan***.

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

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and 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 denial 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 yet 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.

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, nuclear explosion or nuclear accident, radioactive contamination or the hazardous properties of nuclear materials. "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. This does not include a ***covered person*** that is a sole proprietor, partner or executive officer that is not required by law to have workers' compensation or similar coverage and does not have 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 the ***customary and reasonable amount***, the ***allowable claims limits***, or the ***negotiated rate***, as applicable.

6. 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***. This exclusion will not apply to an ***illness*** and/or ***injury*** sustained due to a medical condition (physical or mental) or domestic violence.

7. To the extent that payment under the ***Plan*** is prohibited by any law of any jurisdiction in which the ***covered person*** resides at the time the expense is ***incurred***.

8. Charges for services rendered and/or supplies received prior to the ***effective date*** or after the termination date of a person's coverage.

9. 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.

10. Charges for services, supplies or treatment that are considered ***experimental/investigational***.

11. 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.

12. 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***.

13. 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***.

14. 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*.

15. Claims not submitted within the ***Plan's*** filing limit deadlines as specified in the section, *Medical Claim Filing Procedure*.

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

17. 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, if shown on the primary carrier's explanation of benefits.

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 (30) hours per work week or 1,560 hours per year and salaried elected officials (except for multi-jurisdictional elected officials) shall be eligible to enroll for coverage under the ***Plan***. This does not include temporary or seasonal ***employees*** working less than an average of 30 (thirty) hours per work week over the ***employer's measurement period***.

If applicable under the ***Affordable Care Act***, an ***employee*** of the ***employer*** who is not currently working the minimum number of hours, but was working on average the minimum number of hours during the ***employer's measurement period*** and is eligible during the ***employer's stability period***, as documented by the ***employer*** and consistent with the Affordable Care Act, applicable regulations and regulatory guidance, is eligible to enroll under the ***Plan***, provided the ***employee*** is a member of a class eligible for coverage and has satisfied any waiting period that may be required by the ***employer***.

EMPLOYEE ENROLLMENT

An ***employee*** must file a written application (or electronic, if applicable) with the ***employer*** for coverage hereunder for himself within thirty (30) 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

An ***employer*** may require new ***employees*** to complete a one (1) month, less one (1) day, "reasonable and bona fide" orientation period before the eligibility waiting period begins for the ***employer's*** group health plan. *The Departments envision that an employer and employee will evaluate whether the employment situation is satisfactory for each party, and standard orientation and training processes will begin, during such "orientation period".*

Eligible ***employees***, as described in *Employee Eligibility*, are covered under the ***Plan*** on the first day of the month following the date of hire, 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, as defined by the state in which the ***employee*** was legally married, unless court ordered separation exists. Spouse also includes a common law spouse as defined by the State of Colorado and the ***employee's dependent*** who is a party to a civil union.

   This ***Plan*** intends to comply with the Colorado approved State Bill 13-011, Colorado Civil Union Act, and will provide persons entering into a civil union with the rights, benefits, protections, duties, obligations, and responsibilities currently afforded by Colorado law to spouses, provided a certificate of the civil union exists.

   The term "spouse" shall also include the ***employee's*** domestic partner.

2. The ***employee's*** natural child, stepchild, legally adopted child, child ***placed for adoption***, foster child, and a child for whom the ***employee*** has been appointed legal guardian, through the end of the month in which the child reaches 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 the ***Plan***. Such child shall be referred to as an ***alternate recipient***. ***Alternate recipients*** are eligible for coverage only if the ***employee*** is also covered under the ***Plan***. An application for enrollment must be submitted to the ***employer*** for coverage under the ***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 the end of the month in which the child reached twenty-six (26) years of age and who is unmarried and incapable of self-sustaining employment due to a mental and/or physical disability, will remain eligible for coverage under the ***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***, they may choose to have one covered as the ***employee***, and the spouse covered as the ***dependent*** of the ***employee***, or they may choose to have both covered as ***employees***. 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 (30) days of becoming eligible for coverage; and within thirty (30) 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.

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 (30) 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 (30) days of the date acquired.

3. Newborn children shall be covered from birth, provided the ***employee*** has applied for ***dependent*** coverage within thirty (30) days of birth.

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 (30) 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.

   Notwithstanding any provision of the ***Plan*** to the contrary, all benefits received by an individual under any benefit option, package or coverage under the ***Plan*** shall be applied toward the applicable ***maximum benefit*** paid by the ***Plan*** for any one ***covered person*** for such option, package or coverage under the ***Plan***, and also toward the ***maximum benefit*** under any other options, packages or coverages under the ***Plan*** in which the individual may participate in the future.

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 (30) days from the date of loss of other coverage.

The ***effective date*** of coverage as the result of a special enrollment shall be 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 the ***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 (30) 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 date of such marriage;

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)

For the Traditional Plan

The ***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.

For the High Deductible Health Plan

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 the individual's loss of eligibility is due to termination of coverage 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.

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 as designated by the ***employer***.

During this open enrollment period, an ***employee*** and his ***dependents*** who are covered under the ***Plan*** or covered under any ***employer*** sponsored health plan may elect coverage or change coverage under the ***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 1st.

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. Significant 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.

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 date the ***employee*** ceases to meet the eligibility requirements of the ***Plan***.

3. The date 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. However if the ***employee's*** coverage terminates because of the death of the ***employee***, coverage for the ***dependent(s)*** shall continue until the end of the month in which the ***employee*** dies, provided the ***dependent(s)*** continue to pay the regular contribution for coverage.

3. The date such person ceases to meet the eligibility requirements of the ***Plan***, except that for a ***dependent*** child, termination shall be the last day of the month in which the ***dependent*** child reaches age twenty-six (26).

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***.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents***, when the ***employee*** is on an authorized ***leave of absence*** from the ***employer***.

Coverage shall continue for up to three (3) months (up to six months under certain narrow criteria) for an approved medical leave of absence. The ***employee's*** required contributions shall continue at the same rate as the ***employee*** paid as an active ***employee***.

Coverage shall continue for up to one year for an approved personal leave of absence. The ***employee's*** required contributions shall be the entire cost of coverage.

Any available *Continuation of Coverage* (COBRA) coverage shall begin after the leave of absence coverage ends.

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 the ***Plan*** for up to twelve (12) weeks, or (twenty-six (26) weeks in certain circumstances). ***Employees*** should contact the ***employer*** to determine whether they 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 (30) days of his return to active work.

Repayment Requirement

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

EMPLOYEE REINSTATEMENT

An ***employee*** who returns to work following an approved ***leave of absence*** or ***layoff*** who continued coverage under the ***Plan's*** *Continuation of Coverage* (COBRA) provision is eligible for reinstatement of coverage on the day he returns to active employment. Prior benefits and limitations, such as deductible, out-of-pocket expense limitation, ***Essential Health Benefits***/non-***Essential Health Benefits maximum benefit*** shall be applied with no break in coverage.

An ***employee*** who returns to work following an approved ***leave of absence*** or ***layoff*** who did not continue coverage under the ***Plan's*** *Continuation of Coverage* (COBRA) provision will be considered a new ***employee*** for the purpose of eligibility and will be subject to all eligibility requirements, including all requirements relating to the ***effective date*** of coverage.

An ***employee*** who returns to work following a termination of employment will be considered a new ***employee*** for the purpose of eligibility and will be subject to all eligibility requirements, including all requirements relating to the ***effective date*** of coverage.

CONTINUATION OF COVERAGE

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

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 the ***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.

   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 the ***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 the ***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 the Plan Document.

   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 (60th) 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 the ***Plan*** as a result of the 18-Month Qualifying Event; or
   (iv.) The date on which the person is furnished with a copy of the Plan Document.

   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 the Plan Document.

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 the ***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 the ***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.

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 the ***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 the ***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.

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 a waiting period, regardless of their election of COBRA continuation coverage.

PLAN CONTACT INFORMATION

Questions concerning the ***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 the ***Plan***, ***covered persons*** should keep the ***plan administrator*** (or its designee) informed of any changes to their current addresses.

MEDICAL 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:

   CoreSource, Inc.
   P.O. Box 2310
   Mt. Clemens, MI 48046

   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 and diagnosis code.
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the ***accident***, ***injury*** or ***illness*** being treated.

3. All claims not submitted within one (1) year 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*** 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 in a form approved by the ***plan administrator*** 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 one (1) year 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. 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.
7. 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

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of a denied claim by making written request to the ***claims processor*** 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***, for a full and fair review:

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. However there could be circumstances where the new or additional evidence or rationale could be received so late that it would be impossible to provide the ***covered person*** in time to have a reasonable opportunity to respond. In these circumstances, the period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
   a. The date the ***covered person*** responds to the new or additional rationale or evidence; or
   b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the ***covered person***.
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 ***claims processor*** will not afford deference to the original denial.
6. The ***claims processor*** 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 ***claims processor*** 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 ***claims processor*** 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 ***claims processor*** 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. 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.
6. 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.

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:**

1-866-466-5053

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 ***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.

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 decreased 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. 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.

7. 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

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 ***claims processor*** 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*** for a full and fair review:

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. The period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
   a. The date the ***covered person*** responds to the new or additional rationale or evidence; or
   b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the ***covered person***.
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 ***claims processor*** will not afford deference to the original denial.
6. The ***claims processor*** 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 ***claims processor*** 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 ***claims processor*** 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 ***claims processor*** 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 such a review.
5. 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.
6. 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 the ***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 differ from the medical care or treatment, equipment or supplies that are considered ***covered expenses*** under the ***Plan***.

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***.

POST-SERVICE AND PRE-SERVICE CLAIM EXTERNAL APPEALS PROCEDURE

EXTERNAL APPEAL

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of a denied appeal if the claim determination involves medical judgment or a rescission by making written request to the ***claims processor*** within four (4) months of receipt of notification of the final internal denial of benefits. Medical judgment includes, but is not limited to:

1. ***Medical necessity***;
2. Appropriateness;
3. ***Experimental*** or ***investigational*** treatment;
4. Health care setting;
5. Level of care; and
6. Effectiveness of a ***covered expense***.

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 1st falls on a Saturday, Sunday or Federal holiday.*}

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 the final internal denial was the result of:

1. Medical judgment; or
2. Rescission of coverage under this ***Plan***.

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

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and 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 denial 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 yet 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.

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 ***Essential Health Benefits***/non-***Essential Health Benefits 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 trusteed, 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 that would be payable under this ***Plan*** for each claim in the absence of this provision shall be calculated and reduced by the benefits payable under all other plans for the expenses covered in whole or in part by this ***Plan***.

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. 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. If the ***employee*** and/or ***dependent*** does not elect ***Medicare***, but is otherwise eligible due to end stage renal disease, benefits will be paid as if ***Medicare*** has been elected and this ***Plan*** will pay secondary benefits upon completion of the thirty (30) month "coordination period."

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.

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 ***Essential Health Benefits***/non-***Essential Health Benefits maximum benefit*** 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 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 sponsor of the ***Plan***. The ***employer*** maintains 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 authority shall be given full force and effect.

Notwithstanding any provisions of this ***Plan*** document to the contrary, the ***Plan Sponsor*** has the authority to, and hereby does, allocate certain responsibility to ELAP Services, LLC *(the **Designated Decision Maker** or **DDM**)*. The responsibility allocated to the ***DDM*** is limited to discretionary authority and ultimate decision-making authority with respect to the review and audit of certain claims in accordance with the applicable ***Plan*** provisions under the section, *Claim Review and Audit Program*. Such claims selected as eligible for review and audit shall be identified according to guidelines to which the ***Plan Sponsor*** has agreed, and shall be referred to the ***DDM*** by the ***Plan Administrator*** or its designee. The ***DDM*** shall have no authority, responsibility or liability other than with respect to its duties under the *Claim Review and Audit Program*.

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

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

1. To administer the ***Plan*** in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the ***Plan***;
3. To interpret the ***Plan***, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a ***Plan*** participant's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the ***Plan*** documents and all other records pertaining to the ***Plan***;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting as required by applicable law;
10. To establish and communicate procedures to determine whether a medical child support order or national medical support notice is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the ***Plan's*** administration.

Duties of the Designated Decision Maker
The ***Designated Decision Maker*** shall have the following duties with respect to the *Claim Review and Audit Program*:

1. To administer the ***Plan*** in accordance with its terms;
2. To interpret the ***Plan***, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
3. To make factual findings;
4. To decide disputes which may arise relative to a ***covered person's*** rights;
5. To decide disputes which may arise relative to benefits payable under the ***Plan*** and negotiate settlement, if appropriate;
6. To review appeals of claims under the *Claim Review and Audit Program*, and to uphold or reverse any denials;
7. To perform its duties in conjunction with the provisions of the *Claim Review and Audit Program*; and
8. To keep and maintain records pertaining to the *Claim Review and Audit Program*.

The duties of the ***DDM*** shall be limited to those set forth above.

Payment of Benefits
Benefits will be processed as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits. All covered health benefits are payable to you. However, the ***Plan*** has the right to pay any health benefits to the service provider. This will be done unless you have told the ***claims processor*** otherwise by the time you file the claim and a reasonable amount of time for the ***claims processor*** to process your request.

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***.

The ***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).

Additional Provisions

The ***Plan's***, ***Plan Sponsor's***, ***claim processor's*** or ***DDM's*** failure to implement or insist upon compliance with any provision of this ***Plan*** at any given time or times, shall not constitute a waiver of the right to implement or insist upon compliance with that provision at any other time or times.

APPLICABLE LAW

Except to the extent preempted by federal law, all provisions of the ***Plan*** shall be construed and administered in a manner consistent with the requirements under the laws of the State of Colorado.

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible ***covered person*** is entitled to receive benefits under the ***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 the ***Plan*** is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The original ***effective date*** of this ***Plan*** was January 1, 2000. The ***effective date*** of the modifications contained herein is January 1, 2019.

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***, or otherwise misleads the ***Plan***, 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***, 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*** null and void.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in the ***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 the ***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 the ***Plan*** shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under the ***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

The decision by the ***plan administrator/claims processor*** on review will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law. All claim review procedures provided for in this ***Plan*** Document must be exhausted before any legal or equitable action is brought. Notwithstanding any other state or federal law, any and all legal actions to recover benefits, whether against the ***Plan***, ***plan administrator/claims processor***, any other fiduciary, or their employees, must be filed within one (1) year from the date all claim review procedures provided for in this ***Plan*** Document have been exhausted.

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 the ***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*** 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 the ***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 deductible(s), ***coinsurance*** and ***Essential Health Benefits/***non-***Essential Health Benefits 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*** if the ***plan sponsor*** requests it for the purpose of:

    a. Obtaining premium bids from health plans for providing health insurance coverage under the ***Plan***; or
    b. 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***.

Affordable Care Act

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 and all applicable regulations and regulatory guidance.

Allowable Claim Limit

The charge for services and supplies furnished by a ***hospital,*** an ***ambulatory surgical facility***, a ***facility***, or a ***nonpreferred provider*** that are considered to be ***covered expenses*** under this ***Plan*** and are ***medically necessary*** for the care and treatment of ***illness*** or ***injury***, but only to the extent that such fees are within certain limits as determined by the ***DDM*** and set forth in the *Claim Review and Audit Program* section of this ***Plan***.

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 the ***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. 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***.

Approved Clinical Trial

A Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other" life-threatening disease or condition" and is further described in accordance with federal law and applicable federal regulations.

Birthing 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 *Facts About the Plan* 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***, ***skilled nursing 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 the ***Plan***, or becomes eligible at a later date, and for whom the coverage provided by the ***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 the ***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 90% and is applied to CPT codes using Fair Health benchmarking tables.

For claim determinations made in accordance with the *Claim Review and Audit Program*, ***covered expenses*** will be limited to the ***allowable claim limits***. Please refer to the section entitled, *Claim Review and Audit Program* for the definition of an ***allowable claim limit***.

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

A ***dependent*** is a spouse, common law spouse, ***dependent*** who is a party to a civil union with the ***employee***, domestic partner or child who meets the eligibility requirements in the *Eligibility, Enrollment and Effective Date, Dependent(s) Eligibility* section of this document.

Designated Decision Maker (DDM)

ELAP Services, LLC

Direct Agreement

A written agreement between a ***directly contracted provider*** and the ***DDM*** or the ***plan sponsor*** which contains the terms and conditions under which the ***covered person*** may access discounted fees and/or negotiated or scheduled reimbursement rates which the ***Plan*** adopts as ***allowable claims limits*** for claims submitted by a ***directly contracted provider***.

Directly Contracted Provider

A medical provider which has entered into a ***Direct Agreement*** with the ***DDM*** or the ***plan sponsor*** to provide certain medical services to ***covered persons*** at agreed upon ***allowable claim limits***.

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 the ***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 are 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.

Emergency Services

With respect to an ***emergency*** medical condition, a medical screening examination that is within the capability of the emergency department of a ***hospital***, including ancillary services routinely available to the emergency department to evaluate such ***emergency*** medical condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the ***hospital***, as are required to stabilize the patient.

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 (30) hours per work week or 1,560 hours per year on a ***full-time*** status basis. As used in this document, the term ***employee*** shall include salaried elected officials (except for multi-jurisdictional elected officials) covered under the ***Plan***.

Employer

The ***employer*** is Gunnison County, Colorado.

Essential Health Benefits

Those benefits identified by the U.S. Secretary of Health and Human Services, including benefits for ***covered expenses*** incurred for the following services:

1. Ambulatory patient services;
2. ***Emergency services***;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment ***(mental*** and ***nervous disorder and chemical dependency)***;
6. Prescription drugs;
7. ***Habilitative services***, ***rehabilitative services*** and ***habilitative and rehabilitative devices***;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management;
10. Pediatric services, including oral and vision care.

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***, ***employer/plan administrator***, or their designee must make an independent evaluation of the ***experimental***/non-experimental standings of specific technologies. The ***claims processor***, ***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***, ***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 on-going Phase I or Phase II clinical trials, is in the research, ***experimental***, study or ***investigational*** arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, 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.

Facility

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

Full-time

Employees who are regularly scheduled to work not less than thirty (30) hours per work week or 1,560 hours per year.

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.

Habilitative Services

Medically necessary health care services that help a ***covered person*** keep, learn or improve skills and functioning for daily living. Examples of ***habilitative services*** include therapy for a ***dependent*** child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other ***medically necessary*** services for people with disabilities in a variety of inpatient and/or outpatient settings. ***Habilitative services*** that are not ***medically necessary***, for example when therapy has reached an end point and goals have been reached, will not be a ***covered expense***.

Habilitative and Rehabilitative Devices

Medically necessary devices that are designed to assist a ***covered person*** in acquiring, improving, or maintaining, partially or fully, skills and functioning for daily living. Such devices include, but are not limited to, ***durable medical equipment***, orthotics, prosthetics, and low vision aids.

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, physical sickness, or ***pregnancy*** of a ***covered person***.

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 ***skilled nursing 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.

Layoff

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

Leave of Absence

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

Maximum Benefit [for Essential Health Benefits/non-***Essential Health Benefits]***

Any one of the following, or any combination of the following ***Essential Health Benefits/***non-***Essential Health Benefits***:

1. The maximum amount paid by the ***Plan*** for any one ***covered person*** during the entire time he is covered by the ***Plan***.

2. The maximum amount paid by the ***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 the ***Plan***, or
    b. A specified period of time, such as a calendar year.

3. 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***, or
    c. Visits by a ***home health care agency***.

The ***maximum benefit*** for ***Essential Health Benefits*** and non-***Essential Health Benefits*** is tracked separately.

Measurement Period

The period of time, as determined by the ***employer*** and consistent with Federal law, regulation and guidance, utilized by the ***employer*** to determine whether a ***variable hour employee*** worked on average 30 hours per week for the ***employer***.

Medically Necessary (or Medical Necessity)

Service, supply or treatment which is determined by the ***claims processor***, ***employer/plan administrator*** (or its 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***, ***employer/plan administrator*** (or its designee), may request and rely upon the opinion of a ***physician*** or ***physicians***. The determination of the ***claims processor***, ***employer/plan administrator*** (or its 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/Morbidly Obese

A diagnosed condition in which the body weight of a man is one hundred (100) pounds or the body weight of a woman is eighty (80) 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, Pickwickian syndrome, congestive heart failure, cardiomyopathy, severe musculoskeletal dysfunction, or medically refractory hypertension (blood pressure > 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management), that are either life-threatening or which significantly impair a major life function (e.g., mobility, ability to work, ability to self care).

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 (Nonpreferred)

A ***professional 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***; 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***.

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 Gunnison County, Colorado Employee 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 Gunnison County, Colorado.

Plan Year End

The ***plan year end*** is December 31st.

Preferred Provider (Preferred)

A ***professional 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

The organization, designated by the ***plan administrator***, which selects and contracts with certain ***professional providers*** to provide services, supplies and treatment to ***covered persons*** at a ***negotiated rate***. The ***Preferred Provider Organization's*** name and/or logo is shown on the front of the ***covered person's*** ID card.

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, gynecologist/obstetrician or general internist and has contracted with the network to render services, supplies and treatment to ***covered persons*** and to assist in managing the care of ***covered persons***.

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 licensed ***physician***; surgeon; or any other licensed practitioner required to be recognized by state law, if applicable, and performing services within the scope of such license, who is not a family member.

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.

Rehabilitative Services

Medically necessary health care services that help a ***covered person*** get back, keep, or improve skills for daily living that have been lost or impaired after sickness, ***injury***, or disability. These services assist individuals in improving or maintaining, partially or fully, skills and functioning for daily living. ***Rehabilitative services*** include, but are not limited to, physical therapy, occupational therapy, speech-language pathology and audiology, and psychiatric rehabilitation.

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.

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.

Skilled Nursing 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.

Stability Period

The period of time as determined by the ***employer*** and consistent with Federal law, regulation and guidance, after the ***measurement period*** has been completed.

Total Disability or Totally Disabled

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

Treatment Center

1. An institution which does not qualify as a ***hospital***, but which does provide a program of effective medical and therapeutic treatment for ***chemical dependency***, and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:

    a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
    b. It provides a program of treatment approved by the ***physician***.
    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 Facility

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

Variable Hour Employee

An ***employee*** as defined by Federal law, regulation and guidance.

ADOPTION

Gunnison County, Colorado has caused this Gunnison County, Colorado Employee Medical Benefit Plan (***Plan***) to take effect as of the first day of January 2019, at Gunnison, Colorado. This is a revision of the ***Plan*** previously adopted September 1, 2017. I have read the document herein and certify the document reflects the terms and conditions of the employee welfare benefit plan as established by Gunnison County, Colorado.

BY:_____ DATE:_____