JUNIATA COLLEGE
EMPLOYEE BENEFIT PLAN
PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

Effective Date: January 1, 2011
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GRANDFATHERED STATUS DISCLOSURE

This Juniata College Employee Benefit Plan believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. For example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act. For example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.
SUMMARY PLAN DESCRIPTION

Name of Plan:
Juniata College Employee Benefit Plan

Name, Address and Phone Number of Employer/Plan Sponsor:
Juniata College
1700 Moore Street
Huntingdon, Pennsylvania 16652-2196
814-641-3197

Employer Identification Number:
23-1352652

Plan Number:
501

Group Number:
529

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:
Juniata College
1700 Moore Street
Huntingdon, Pennsylvania 16652-2196
814-641-3197

Legal process may be served upon the plan administrator.

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

For detailed information regarding a person being ineligible for benefits through reaching maximum benefit levels, 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.

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

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.
26-28 W. King Street
Lancaster, Pennsylvania 17603

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

Caremark
211 Commerce Street, Suite 800
Nashville, TN 37201

Statement of ERISA Rights:

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

1. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, if applicable.

2. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description, if applicable. The plan administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report, if applicable.

4. Continue health care coverage for the participant, the participant's spouse or dependents if there is a loss of coverage under the Plan as the result of a qualifying event. The participant or dependent may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.
In addition to creating rights for Plan participants, ERISA imposes obligations upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all Plan participants.

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

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

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

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

Participants should contact the plan administrator for questions about the Plan. For questions about this statement or about rights under ERISA, participants should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in their telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.
# 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 Claim Filing Procedure, Medical Expense Benefit, Medical Exclusions, Prescription Drug Program, Plan Exclusions and Preferred Provider or Nonpreferred Provider.

## Medical Benefits

<table>
<thead>
<tr>
<th>Maximum Benefit Per Covered Person While Covered By This Plan For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Aid</td>
</tr>
<tr>
<td>Diabetic Education Consultation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximum Benefit Per Covered Person Per Calendar Year For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Care</td>
</tr>
<tr>
<td>Preventive Health Care For Adults – age eighteen (18) and older</td>
</tr>
<tr>
<td>Well Child Care – through age eighteen (18)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximum Benefit Per Covered Person Per Condition Per Calendar Year For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Speech and Occupational Therapy Services Combined</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximum Benefit Per Covered Person Per Confinement For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Care Facility</td>
</tr>
</tbody>
</table>

## Deductible Per Calendar Year: | Preferred Provider | Nonpreferred Provider |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Deductible (Per Person)</td>
<td>$0</td>
<td>$300</td>
</tr>
<tr>
<td>Family Deductible (Two Individuals)</td>
<td>$0</td>
<td>$600</td>
</tr>
</tbody>
</table>

## Copay Per Admission: (Refer to Medical Expense Benefit, Copay) | Preferred Provider | Nonpreferred Provider |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Inpatient Hospital Admission</td>
<td>$25</td>
<td>$0</td>
</tr>
</tbody>
</table>

## Out-of-Pocket Expense Limit Per Calendar Year: | Preferred Provider | Nonpreferred Provider |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual (Per Person)</td>
<td>N/A</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family (Two Individuals)</td>
<td>N/A</td>
<td>$4,000</td>
</tr>
</tbody>
</table>

Refer to Medical Expense Benefit, Out-of-Pocket Expense Limit for a listing of charges not applicable to the out-of-pocket expense limit.
Coinsurance:

The Plan pays the percentage listed on the following pages for covered expenses incurred by a covered person during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the Plan pays one hundred percent (100%) of covered expenses for the remainder of the calendar year or until the maximum benefit has been reached. Refer to Medical Expense Benefit, Out-of-Pocket Expense Limit, for a listing of charges not applicable to the one hundred percent (100%) coinsurance.

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>100% after $25 copay per admission</td>
<td>80%</td>
</tr>
<tr>
<td>Preadmission Testing</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient Surgery/Ambulatory Surgical Center</td>
<td>100% after $10 copay</td>
<td>80%</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>Facility Services 100% after $25 copay</td>
<td>*100% after $25 copay</td>
</tr>
<tr>
<td></td>
<td>(Copay waived if admitted)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician Services 100%</td>
<td>*100%</td>
</tr>
<tr>
<td>Non-Emergency Use of the Emergency Room</td>
<td>Facility Services 100% after $25 copay</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Physician Services 100%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Ambulance 100%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Immediate Care Center 100% after $10 copay</td>
<td>80%</td>
</tr>
<tr>
<td>Physician's Services</td>
<td>Inpatient Visit 100%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Office Visit 100% after $10 copay</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Injections 100%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Surgery 100%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Pathology 100%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Anesthesiology 100%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Radiology 100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

* Deductible Waived
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th><strong>Preferred Provider</strong> (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th><strong>Nonpreferred Provider</strong> (% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic X-rays &amp; Lab</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Inpatient or Outpatient</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Extended Care Facility</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Limitation: 90 days <em>maximum benefit per confinement</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Well Child Care &amp; Immunizations</td>
<td>100% after $10 copay</td>
<td>80%</td>
</tr>
<tr>
<td>Limitation: through age eighteen (18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Preventive Care</td>
<td>100% after $10 copay</td>
<td>80%</td>
</tr>
<tr>
<td>Limitation: age nineteen (19) and over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Examination</td>
<td>100% after $10 copay</td>
<td>80%</td>
</tr>
<tr>
<td>Limitation: See Medical Expense Benefit, Preventive Health Schedule For Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Hearing Aids</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Limitation: $1,000 <em>maximum benefit while covered by this Plan</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Gynecological Examination and Pap Smear</td>
<td>100% after *80%</td>
<td>*80%</td>
</tr>
<tr>
<td>Limitation: See Medical Expense Benefit, Preventive Health Schedule For Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Mammograms</td>
<td>100%</td>
<td>*80%</td>
</tr>
<tr>
<td>Limitation: See Medical Expense Benefit, Preventive Health Schedule For Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Prostate Examination &amp; PSA Test</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Limitation: See Medical Expense Benefit, Preventive Health Schedule For Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Colorectal Cancer Screening</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Limitation: See Medical Expense Benefit, Preventive Health Schedule For Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken Pox Vaccine (VZV) Purchased at a Pharmacy</td>
<td>100%</td>
<td>*100%</td>
</tr>
<tr>
<td>Limitation: See Medical Expense Benefit, Preventive Health Schedule For Adults</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Deductible Waived
## Benefit Description

<table>
<thead>
<tr>
<th>Mental &amp; Nervous Disorders and Chemical Dependency Care</th>
<th>Preferred Provider (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Nonpreferred Provider (% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Services</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Partial Confinement</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>100% after $10 copay</td>
<td>50%</td>
</tr>
<tr>
<td>Physical, Speech and Occupational Therapy Services</td>
<td>100% after $10 copay</td>
<td>80%</td>
</tr>
<tr>
<td>Limitation: 60 consecutive days or 25 visits, whichever is greater, maximum benefit per condition, per calendar year - all therapies combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy Services – Other</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Birthing Facility</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>100% after $10 copay</td>
<td>80%</td>
</tr>
<tr>
<td>Limitation: 25 visits maximum benefit per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>100% after $10 copay</td>
<td>80%</td>
</tr>
<tr>
<td>Other Chiropractic Services</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>100% after $10 copay</td>
<td>80%</td>
</tr>
<tr>
<td>Office Visit</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Other Podiatry Services</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Diabetic Education Consultation</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Limitation: One (1) consultation maximum benefit while covered by this Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetics/Orthotics</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>CVS Caremark Specialty Pharmacy Program</td>
<td>100% *100%</td>
<td></td>
</tr>
<tr>
<td>Other Prescription Drugs</td>
<td>See Prescription Drug Program</td>
<td></td>
</tr>
<tr>
<td>All Other Covered Expenses</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

* Deductible Waived

Refer to *Medical Expense Benefit* for complete details.
### Pharmacy Option

<table>
<thead>
<tr>
<th>Prescription Drug Card</th>
<th>The Plan pays 100% after calendar year deductible is met (if applicable) and after payment of copay amount for each prescription purchased at a pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>Per Person: $50</td>
</tr>
<tr>
<td>Copay Per Prescription</td>
<td>Generic: $10 copay (no deductible) Preferred Brand Name: 10% with a minimum $20 copay and a maximum $100 copay Nonpreferred Brand Name: 10% with a minimum $40 copay and a maximum $100 copay</td>
</tr>
<tr>
<td>Limitation:</td>
<td>34 day supply</td>
</tr>
</tbody>
</table>

If the *covered person* purchases a brand name drug when the *physician* has indicated a *generic drug* can be dispensed, the *covered person* will be required to pay the difference between the cost of the *generic drug* and the brand name requested, plus the usual *copay*.

### Mail Order Option

<table>
<thead>
<tr>
<th>Mail Order Prescription</th>
<th>100% after copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copay Per Prescription</td>
<td>Generic: $20 copay Preferred Brand Name: $40 copay Nonpreferred Brand Name: $80 copay</td>
</tr>
<tr>
<td>Limitation:</td>
<td>90 day supply</td>
</tr>
</tbody>
</table>

If the *covered person* purchases a brand name drug when the *physician* has indicated a *generic drug* can be dispensed, the *covered person* will be required to pay the difference between the cost of the *generic drug* and the brand name requested, plus the usual *copay*.

Refer to *Prescription Drug Program* for complete details.
PREFERRED PROVIDER
OR NONPREFERRED PROVIDER

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

PREFERRED PROVIDER

A preferred provider is a physician, hospital or ancillary service provider which has an agreement in effect with the Preferred Provider Organization (PPO) to accept a reduced rate for services rendered to covered persons. This is known as the negotiated rate. The preferred provider cannot bill the covered person for any amount in excess of the negotiated rate. Covered persons should contact the employer’s Human Resources Department for a current listing of preferred providers.

NONPREFERRED PROVIDER

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

REFERRALS

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

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by a nonpreferred provider where covered expenses shall be payable at the preferred provider coinsurance level and as regards covered expenses for an emergency, paid at the greatest of the following three amounts: the amount negotiated with preferred providers for such covered expenses, or the amount determined as the customary and reasonable amount, or the amount that would be paid under Medicare for such emergency:

1. Emergency treatment rendered at a nonpreferred provider facility or at a preferred provider facility by a nonpreferred provider. If the covered person is admitted to the hospital on an emergency basis, covered expenses shall be payable at the preferred provider level. The in-network benefit will continue for the duration of the hospitalization if emergency admission was required (e.g., heart attack, serious accident).

2. Nonpreferred anesthesiologist when the operating surgeon is a preferred provider and/or the facility where such services are rendered is a preferred provider.

3. Nonpreferred assistant surgeon if the operating surgeon is a preferred provider.

4. Radiologist or pathologist services for interpretation of x-rays and diagnostic laboratory and surgical pathology tests rendered by a nonpreferred provider when the facility where such services are rendered is a preferred provider.

5. Diagnostic laboratory and surgical pathology tests referred to a nonpreferred provider by a preferred provider.
6. While the *covered person* is confined to a *preferred provider hospital*, the *preferred provider physician* requests a consultation from a *nonpreferred provider*, or a newborn visit is performed by a *nonpreferred provider*.

7. *Medically necessary* specialty services, supplies or treatments which are not available from a provider within the *Preferred Provider Organization*.

8. When a covered *dependent* resides outside the service area of the *Preferred Provider Organization*, for example a *full-time student*.

9. Treatment rendered at a *facility* of the uniformed services or Indian Health Care *facility*. 
MEDICAL EXPENSE BENEFIT

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

COPAY

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

The copay will not be applied toward the following:

1. The calendar year deductible.
2. The maximum out-of-pocket expense limit.
3. The deductible carry-over.
4. The common accident deductible.
5. The multiple birth 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.

Two Individual Deductible

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

Deductible Carry-Over

Amounts incurred during October, November and December and applied toward the deductible of any covered person, will also be applied to the deductible of that covered person in the next calendar year. Deductible carry-over does not apply to family deductibles.

Common Accident

If two or more covered members of a family are injured in the same accident and, as a result of that accident, incur covered expenses, only one (1) individual deductible amount will be deducted from the total covered expenses of all covered family members related to the accident for the remainder of the calendar year.
Multiple Birth Deductible

When two (2) or more dependents are born in a multiple birth, only one (1) individual deductible will be taken from the total covered expenses incurred in a calendar year for those dependents if the covered expenses are incurred in the same calendar year as the birth and are due to:

1. Premature birth; or
2. Abnormal congenital conditions; or
3. Injury which is received at birth or illness which starts not more than thirty (30) days after birth.

COINSURANCE

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

OUT-OF-POCKET EXPENSE LIMIT

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

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

Out-of-Pocket Expense Limit Exclusions

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

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

MAXIMUM BENEFIT

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

HOSPITAL/AMBULATORY SURGICAL FACILITY

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

Covered expenses shall include:

1. Room and board for treatment in a hospital, including intensive care units, cardiac care units and similar medically necessary accommodations. Covered expenses for room and board shall be limited to the hospital’s semiprivate rate. Covered expenses for intensive care or cardiac care units shall be the customary and reasonable amount for nonpreferred providers and the percentage of the negotiated rate for preferred providers. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the covered person.
2. Miscellaneous hospital services, supplies, and treatments including, but not limited to:
   a. Admission fees, and other fees assessed by the hospital for rendering services, supplies and treatments;
   b. Use of operating, treatment or delivery rooms;
   c. Anesthesia, anesthesia supplies and its administration by an employee of the hospital;
   d. Medical and surgical dressings and supplies, casts and splints;
   e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
   f. Drugs and medicines (except drugs not used or consumed in the hospital);
   g. X-ray and diagnostic laboratory procedures and services;
   h. Oxygen and other gas therapy and the administration thereof;
   i. Therapy services.

3. Services, supplies and treatments described above furnished by an ambulatory surgical facility, 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 within seven (7) days prior to a hospital admission which are related to the condition which is necessitating the confinement. Such tests shall be payable 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.

FACILITY PROVIDERS

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

AMBULANCE SERVICES

Covered expenses shall include:

1. Ambulance services for air or ground transportation for the covered person from the place of injury or serious medical incident to the nearest hospital where treatment can be given.

2. Ambulance service is covered in a non-emergency situation only to transport the covered person to or from a hospital or between hospitals for required treatment when such transportation is certified by the attending physician as medically necessary. Such transportation is covered only from the initial hospital to the nearest hospital qualified to render the special treatment.

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

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

EMERGENCY ROOM SERVICES

Coverage for emergency room treatment shall be paid in accordance with the Schedule of Benefits provided the condition meets the definition of emergency herein. Emergency accident care must begin within twenty-four (24) hours of the injury in order to be eligible for benefits.

The emergency room copay shall be waived if the patient is admitted directly into the hospital.

NON-EMERGENCY USE OF THE EMERGENCY ROOM

Emergency room treatment for conditions that do not meet the definition of emergency will be considered non-emergency use of the emergency room and will be payable as shown on the Schedule of Benefits.
IMMEDIATE CARE CENTER

Covered expenses shall include charges for treatment in an immediate care center, 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:

1. Medical treatment, services and supplies including, but not limited to: office visits, inpatient visits, home visits.

2. Surgical treatment. Separate payment will not be made for inpatient pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

   For related operations or procedures performed through the same incision or in the same operative field, covered expenses shall include the surgical allowance for each procedure.

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

3. Surgical assistance provided by a physician or professional provider if it is determined that the condition of the covered person or the type of surgical procedure requires such assistance.

4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office.

5. Consultations requested by the attending physician during a hospital confinement. Consultations do not include staff consultations that are required by a hospital's rules and regulations.

6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

SECOND SURGICAL OPINION

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

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

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

DIAGNOSTIC SERVICES AND SUPPLIES

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

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

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

1. When the recipient is covered under this Plan, the Plan will pay the recipient's **covered expenses** related to the transplant.
2. When the donor is covered under this Plan, the Plan will pay the donor's **covered expenses** related to the transplant.
3. Expenses incurred by the donor who is not ordinarily covered under this Plan according to eligibility requirements will be **covered expenses** to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this Plan. The donor's expense shall be applied to the recipient's **maximum benefit**. In no event will benefits be payable in excess of the **maximum benefit** still available to the recipient.
4. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a **covered expense** under this Plan.

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

**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:

1-800-480-6658

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; or when the pregnancy is a result of rape or incest.

**BIRTHING CENTER**

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

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

INFERTILITY SERVICES

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

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

WELL NEWBORN CARE

The Plan shall cover well newborn care as part of the mother's claim while the mother is confined for delivery.

Such care shall include, but is not limited to:

1. Physician services
2. Hospital services
3. Circumcision

WELL CHILD CARE

Covered expenses for well child care shall include charges for the following services provided to covered dependent children, through age eighteen (18): routine pediatric examinations for a reason other than to diagnose an injury or illness; routine immunizations; routine laboratory and other tests given in connection with pediatric examinations; routine hearing and vision examinations.

ROUTINE PREVENTIVE CARE

PREVENTIVE HEALTH SCHEDULE FOR ADULTS

<table>
<thead>
<tr>
<th></th>
<th>18 to 29</th>
<th>30 to 39</th>
<th>40 to 49</th>
<th>50 to 64</th>
<th>65+</th>
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</thead>
<tbody>
<tr>
<td>Physical exams/</td>
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<tr>
<td>health guidance</td>
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<tr>
<td>Blood pressure</td>
<td>At age 18 and annually thereafter as recommended by physician</td>
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<tr>
<td>screening</td>
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<tr>
<td>Pelvic exam</td>
<td>At each physician visit. Minimum of once every two years, annually for those with high blood pressure.</td>
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<tr>
<td>Breast exam by</td>
<td>Every year or as recommended by physician</td>
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<tr>
<td>physician</td>
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<tr>
<td>DIAGNOSTIC SCREENING</td>
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<tr>
<td>Glucose testing</td>
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<tr>
<td>Lipid panel</td>
<td>High risk: routine screening at age 20</td>
<td>Men: routine screening from age 35</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>Women: routine screening from age 45</td>
</tr>
<tr>
<td>Mammogram</td>
<td>High risk: family history or physician recommended</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Every year</td>
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<tr>
<td>Pap test</td>
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<tr>
<td>Chlamydia</td>
<td></td>
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<td>Annually, if sexually active.</td>
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<tr>
<td>Bone/mineral density</td>
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<tr>
<td>screening (for women)</td>
<td></td>
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<td></td>
<td>Routine screening up to once every 2 years if you are at high risk for osteoporosis.</td>
</tr>
</tbody>
</table>
## PREVENTIVE HEALTH SCHEDULE FOR ADULTS
(continued)

<table>
<thead>
<tr>
<th>Test</th>
<th>Prostate cancer screening</th>
<th>Colorectal cancer screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk: family history or physician recommended</td>
<td>Discuss the risks and benefits of prostate cancer screening with your doctor. Testing may include a prostate-specific antigen (PSA) test and/or a digital rectal exam.</td>
<td>Beginning at age 50, annual screening with fecal occult blood test or screening with flexible sigmoidoscopy or double-contrast barium enema every five years or colonoscopy every 5 years</td>
</tr>
<tr>
<td>Electrocardiogram (EKG)</td>
<td>Every 5 years</td>
<td>Every 5 years</td>
</tr>
<tr>
<td>Complete Blood Count (CBC)</td>
<td>Every 5 years</td>
<td>Every 5 years</td>
</tr>
<tr>
<td>Fasting Blood Sugar (FBS)</td>
<td>Every 5 years</td>
<td>Every 5 years</td>
</tr>
<tr>
<td>Urinalysis, routine (UA)</td>
<td>Every 5 years</td>
<td>Every 5 years</td>
</tr>
</tbody>
</table>

### IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus injections</td>
<td>Once every 10 years for all adults</td>
</tr>
<tr>
<td>Measles/mumps/rubella (MMR) vaccine</td>
<td>As recommended by your doctor; two doses for those at high risk</td>
</tr>
<tr>
<td>Pneumococcal vaccine</td>
<td>Once between ages 18 and 64, if you’re at high risk for pneumonia</td>
</tr>
<tr>
<td>Influenza vaccine</td>
<td>Annually between ages 18 and 49, if you’re at high risk for the flu</td>
</tr>
<tr>
<td>Chicken pox vaccine (VZV)</td>
<td>One series of two doses at least one month apart for adults with no history of chicken pox</td>
</tr>
<tr>
<td>Hepatitis A series</td>
<td>High risk: one two-dose series</td>
</tr>
<tr>
<td>Hepatitis B series</td>
<td>High risk: three doses for persons with medical, behavioral, occupational or other indications</td>
</tr>
<tr>
<td>Meningococcal vaccine</td>
<td>High risk: once between ages 18 and 64</td>
</tr>
<tr>
<td>HPV vaccine</td>
<td>Covered ages 11-26; for all women with an abnormal Pap test; over 35 with normal pap once every 3 years</td>
</tr>
</tbody>
</table>

### THERAPY SERVICES

Physical therapy, speech therapy and occupational therapy services are subject to the **maximum benefit** specified on the Schedule of Benefits. **Outpatient** infusion therapy services are subject to pre-certification. Therapy services must be ordered by a **physician** to aid restoration of normal function lost due to **illness** or **injury**.

**Covered expenses** shall include:

1. Services of a **professional provider** for physical therapy, occupational therapy, speech therapy or respiratory therapy.
2. Radiation therapy and chemotherapy.
3. Dialysis therapy or treatment.
4. Infusion therapy.

### EXTENDED CARE FACILITY

**Extended care facility confinement** is subject to pre-certification. Failure to obtain pre-certification may result in a reduction of benefits as specified in the **Medical Claim Filing Procedure** section of this document.
Extended care facility services, supplies and treatments shall be a covered expense provided the covered person is under a physician's continuous care and the physician certifies that the covered person must have twenty-four (24) hours-per-day nursing care.

If the covered person is discharged from the extended care facility and again becomes an inpatient in such facility within one (1) day of the original discharge, it is considered one (1) period of confinement.

Covered expenses shall include:

1. **Room and board** (including regular daily services, supplies and treatments furnished by the extended care facility) limited to the facility's average semiprivate room rate; and

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

Extended care facility benefits are subject to the maximum benefit specified on the Schedule of Benefits.

**HOME HEALTH CARE**

Home health care is subject to pre-certification.

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

1. Part-time or intermittent nursing care by a nurse;

2. Physical, respiratory, occupational or speech therapy;

3. Part-time or intermittent home health aide services for a covered person who is receiving covered nursing or therapy services;

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.

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.

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.

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

DURABLE MEDICAL EQUIPMENT

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

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

PROSTHESSES

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

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a covered expense. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered.
**DENTAL SERVICES**

*Covered expenses* shall include repair of sound natural teeth or surrounding tissue provided it is the result of an injury. Treatment must begin within three hundred sixty-five (365) days of the date of such injury. Damage to the teeth as a result of chewing or biting shall not be considered an injury under this benefit.

Oral surgery includes excision of partially or completely unerupted impacted teeth, closed or open reduction of fractures or dislocations of the jaw, and excision of cysts or tumors of the mouth.

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

**SPECIAL EQUIPMENT AND SUPPLIES**

*Covered expenses* shall include medically necessary special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract surgery; soft lenses or sclera shells intended for use in the treatment of illness or injury of the eye; support stockings, such as Jobst stockings; a wig or hairpiece when required due to chemotherapy, surgery or burns, limited to one (1) while covered by this Plan; surgical dressings and other medical supplies ordered by a professional provider in connection with medical treatment, but not common first aid supplies.

**COSMETIC/RECONSTRUCTIVE SURGERY**

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

1. A *covered person* receives an injury as a result of an accident and as a result requires surgery. *Cosmetic* or *reconstructive surgery* and treatment must be for the purpose of restoring the *covered person* to his normal function immediately prior to the accident.

2. It is required to correct a congenital anomaly, for example, a birth defect, for a child.

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

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

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

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

1. reconstruction of a surgically removed breast; and

2. surgery and reconstruction of the other breast to produce a symmetrical appearance.

Prostheses (and medically necessary replacements) and physical complications from all stages of mastectomy, including lymphedemas will also be considered *covered expenses* following all medically necessary mastectomies.
MENTAL & NERVOUS DISORDERS AND CHEMICAL DEPENDENCY CARE

Inpatient or Partial Confinement

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

Covered expenses shall include:

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

Outpatient

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

PRESCRIPTION DRUGS

Prescription drugs shall be covered under the Prescription Drug Program, except specialty drugs as specified on the Schedule of Benefits and under the CVS Caremark Specialty Pharmacy Program section below.

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

CVS CAREMARK SPECIALTY PHARMACY PROGRAM

The CVS Caremark Specialty Pharmacy Program is available for some specialty drugs. Specialty drugs are often high cost pharmaceuticals used in the management of chronic and/or complex conditions. To receive these specialty drugs, CVS Caremark Specialty Pharmacy will contact the covered person and the covered person’s physician to arrange for the distribution of the specialty drug directly from the CVS Caremark Specialty Pharmacy. Refer to the Schedule of Benefits section for benefit information regarding specialty drugs.

PODIATRY SERVICES

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

PRIVATE DUTY NURSING

Medically necessary services of a private duty nurse shall be a covered expense.
CHIROPRACTIC CARE

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

PATIENT EDUCATION

Covered expenses shall include medically necessary patient education programs including, but not limited to diabetic education and ostomy care. Consultations for diabetic education shall be subject to the maximum benefit as shown on the Schedule of Benefits.

SURCHARGES

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

OUTPATIENT CARDIAC REHABILITATION PROGRAMS

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

CONTRACEPTIVES

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

Charges for oral contraceptives (birth control pills) shall be covered under the Prescription Drug Program only.
MEDICAL EXCLUSIONS

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

1. Charges for services, supplies or treatment for the reversal of surgical sterilization procedures.

2. Charges for services, supplies or treatment related to the treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate mother, embryo implantation, or gamete intrafallopian transfer (GIFT).

3. Charges for oral contraceptives (birth control pills), regardless of whether such pills are to be used for contraceptive or medical reasons.

4. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment. However, treatment of congenital hermaphroditism is a covered expense.

5. Charges for treatment or surgery for sexual dysfunction or inadequacies unless related to injury or organic illness.

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

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

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

9. Charges for biofeedback therapy.

10. Charges for services, supplies or treatments which are primarily educational in nature, except as specified in Medical Expense Benefit, Patient Education; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

11. Charges for marital, career or legal counseling.

12. Except as specifically stated in Medical Expense Benefit, Dental Services, charges for or in connection with: treatment of injury or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

13. Charges for routine vision examinations and eye refractions; vision therapy (orthoptics); eyeglasses or contact lenses, except as specified stated under Medical Expense Benefit, Special Equipment and Supplies; dispensing optician's services.

14. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.
15. Except as medically necessary for the treatment of metabolic or peripheral-vascular illness, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

16. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a physician, such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment.

17. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.

18. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts.

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

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

21. Charges for services provided to a covered person for an elective abortion (See Medical Expense Benefit, Pregnancy for specifics regarding the coverage of abortions).

22. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and hospital confinements for weight reduction programs. However, office visits in connection with weight reduction shall be a covered expense.

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

25. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid, except as specifically provided herein.

26. Charges for an employment physical or any related charges, premarital lab work, and other care not associated with treatment or diagnosis of an illness or injury, except as specified herein. (See Medical Expense Benefit, Routine Preventive Care for specifics.)


28. Charges for methods of treatment to alter vertical dimension.

29. Charges for treatment of temporomandibular joint dysfunction (TMJ) and related conditions by any method.

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, except as specified herein.
33. Charges for expenses related to hypnosis.

33. Charges for prescription drugs or for the Prescription Drug copay applicable to the Prescription Drug Program. Outpatient prescription drugs are paid under the Prescription Drug Program and under no other provision of this Plan.

34. Charges for professional services billed by a professional provider who is an employee of a hospital or any other facility and who is paid by the hospital or other facility for the service provided.

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

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

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

38. Charges for massage therapy, sex therapy, diversional therapy or recreational therapy.

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

40. Charges for holistic medicines or providers of naturopathy.

41. Charges for or related to the following types of treatment:
   a. primal therapy;
   b. rolfing;
   c. psychodrama;
   d. megavitamin therapy;
   e. visual perceptual training.

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

43. Charges for exercise programs for treatment of any condition, except as specified herein.

44. Charges for any services, supplies or treatment not specifically provided herein.
PRESCRIPTION DRUG PROGRAM

PHARMACY OPTION DEDUCTIBLE

The pharmacy option deductible is the dollar amount of covered expense that each covered person must have incurred for the purchase of prescription drugs under the pharmacy option during each calendar year before the Plan pays applicable benefits under the Prescription Drug Program. The pharmacy option deductible amount is shown on the Schedule of Benefits. The pharmacy option deductible amount is not a covered expense under the Medical Expense Benefit.

PHARMACY OPTION

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

PHARMACY OPTION COPAY

After the pharmacy option deductible is met (if applicable), the copay is applied to each covered pharmacy drug charge and is shown on the Schedule of Benefits. The copay amount is not a covered expense under the Medical Expense Benefit. Any one prescription is limited to a thirty-four (34) day supply.

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

If the covered person purchases a brand name drug when the physician has indicated a generic drug can be dispensed, the covered person will be required to pay the difference between the generic drug and the brand name requested, plus the usual copay.

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs which may be prescribed for heart disease, high blood pressure, asthma, etc.).

MAIL ORDER OPTION COPAY

The copay is applied to each covered mail order prescription charge and is shown on the Schedule of Benefits. It 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 the physician has indicated a generic drug can be dispensed, the covered person will be required to pay the difference between the generic drug and the brand name requested, plus the usual copay.

COVERED PRESCRIPTION DRUGS

1. Drugs prescribed by a physician that require a prescription either by federal or state law, including injectables and insulin, except drugs excluded by the Plan.
2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.
3. Insulin, insulin needles and syringes and diabetic supplies.
4. Allergy serums.
5. Oral contraceptives, regardless of the reason prescribed.
7. Smoking cessation drugs.
8. 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.
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, or any prescription directing administration by injection (other than insulin).
11. A charge for infertility medication.
12. A charge for minerals.
14. A charge for medications that are cosmetic in nature (i.e., treating hair loss, wrinkles, etc.).
15. A charge for Tretinoins, all dosage forms, for covered persons up to age twenty-six (26).
17. A charge for drugs used in the treatment of erectile dysfunction (i.e., Viagra).
18. A charge for non-legend drugs, other than as specifically listed herein.

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.
APPELLING A DENIED POST-SERVICE PRESCRIPTION DRUG CLAIM

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

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

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

1. The covered person has the right to submit documents, information and comments.
2. The covered person has the right to access, free of charge, relevant information to the claim for benefits.
3. The review takes into account all information submitted by the covered person, even if it was not considered in the initial benefit determination.
4. The review by the named fiduciary will not afford deference to the original denial.
5. The named fiduciary will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
6. If original denial was, in whole or in part, based on medical judgment:
   a. The named fiduciary will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment; and
   b. The professional provider utilized by the named fiduciary will be neither:
      (i.) An individual who was consulted in connection with the original denial of the claim, nor
      (ii.) A subordinate of any other professional provider who was consulted in connection with the original denial.
7. If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

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

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

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

1. The specific reasons for the denial.
2. Reference to specific Plan provisions on which the denial is based.
3. A statement that the covered person has the right to access, free of charge, relevant information to the claim for benefits.
4. A statement that if the covered person’s appeal is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
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/ investigative 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.
PLAN EXCLUSIONS

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

1. Charges for services, supplies or treatment from any hospital owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.

2. Charges for an injury sustained or illness contracted while on active duty in military service, unless payment is legally required.

3. Charges for services, treatment or supplies for treatment of illness or injury which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

4. Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the covered person fails to claim rights to such benefits or fails to enroll or purchase such coverage.

5. Charges in connection with any illness or injury arising out of or in the course of any employment intended for wage or profit, including self-employment.

6. Charges made for services, supplies and treatment which are not medically necessary for the treatment of illness or injury, or which are not recommended and approved by the attending physician, except as specifically stated herein, or to the extent that the charges exceed customary and reasonable amount or exceed the negotiated rate, as applicable.

7. Charges in connection with any illness or injury of the covered person resulting from or occurring during commission or attempted commission of a criminal battery or felony by the covered person.

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

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

10. Any services, supplies or treatment for which the covered person is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

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

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

13. Charges for services, supplies or treatment rendered by any individual who is a close relative of the covered person or who resides in the same household as the covered person.
14. Charges for services, supplies or treatment rendered by physicians or professional providers beyond the scope of their license; for any treatment, confinement or service which is not recommended by or performed by an appropriate professional provider.

15. Charges for illnesses or injuries suffered by a covered person due to the action or inaction of any party if the covered person fails to provide information as specified in the section, Subrogation/Reimbursement.

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

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

18. Charges for expenses in connection with an injury arising out of or relating to an accident involving the maintenance or use of a motor vehicle (other than a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle, motorized pedal cycle or like type vehicle). This exclusion shall apply to those expenses up to the minimum amount required by law in the state of residence for any injury arising out of an accident of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance. However, this exclusion does not apply to a covered person who is a non-driver when involved in an uninsured motor vehicle accident.

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

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

EMPLOYEE ELIGIBILITY

All full-time employees regularly scheduled to work at least thirty-two (32) hours per work week shall be eligible to enroll for coverage under this Plan. This does not include temporary or seasonal employees.

Retired employees may continue coverage by paying the applicable contribution for employee and/or dependent coverage. While the employer expects retiree coverage to continue, the employer reserves the right to modify or discontinue retiree coverage or any other provision of the Plan at any time.

EMPLOYEE ENROLLMENT

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

EMPLOYEE(S) EFFECTIVE DATE

Eligible employees, as described in Employee Eligibility, are covered under the Plan on the first day of the month coincident with or next 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 with a person of the opposite sex, unless court ordered separation exists.

2. The term “domestic partner” means a same or opposite sex partner of the employee, based on the Plan’s definition.

3. The term “child” means the employee’s natural child, stepchild, legally adopted child, a child for whom the employee or covered spouse has been appointed legal guardian and a child of an employee’s domestic partner, provided the child is less than twenty-six (26) years of age and is not eligible to enroll in any other employer sponsored group health plan, other than through a parent.

4. An eligible child shall also include any other child of an employee or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan, even if the child is not residing in the employee’s household. Such child shall be referred to as an alternate recipient. Alternate recipients are eligible for coverage regardless of whether the employee elects coverage for himself. An application for enrollment must be submitted to the employer for coverage under this Plan. The employer/plan administrator shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the Plan pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the employer/plan administrator shall determine whether such order is a 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.
5. A dependent child who was covered under the Plan prior to reaching the maximum age limit of twenty-six (26) years and who lives with the employee, is unmarried, incapable of self-sustaining employment and dependent upon the employee for support due to a mental and/or physical disability, will remain eligible for coverage under this Plan beyond the date coverage would otherwise terminate.

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

a. Cessation of the mental and/or physical disability;

b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible employee may enroll eligible dependents. However, if both spouses are employees, they may choose to have one spouse covered as the employee, and the other spouse covered as the dependent of the employee, or they may choose to have both spouses 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-one (31) days of becoming eligible for coverage; and within thirty-one (31) days of marriage or the acquiring of children or birth of a child. The employee shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder.

An employee must file an Affidavit of Domestic Partnership for coverage hereunder for his or her eligible domestic partner. Employees should contact their Human Resources Department for additional information regarding completion of an Affidavit of Domestic Partnership.

**DEPENDENT(S) EFFECTIVE DATE**

Eligible dependent(s), as described in Dependent(s) Eligibility, will become covered under the Plan on the later of the dates listed below, provided the employee has enrolled them in the Plan within thirty-one (31) days of meeting the Plan's eligibility requirements and any required contributions are made.

1. The date the employee's coverage becomes effective.
2. The date the dependent is acquired, provided the employee has applied for dependent coverage within thirty-one (31) days of the date acquired.
3. Newborn children will be considered a dependent under this Plan for thirty-one (31) days immediately following birth. For coverage under the Plan for the newborn beyond that date, the employee must submit an application for enrollment within thirty-one (31) days of birth.
4. Coverage for a newly adopted or to be adopted child shall be effective on the date the child is placed for adoption, provided the employee has applied for dependent coverage within thirty-one (31) days of the date the child is placed for adoption.

**SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)**

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

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

Notwithstanding any provision of this 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 maximum benefit paid by this 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-one (31) days from the date of loss of other coverage.

The addition of coverage for a domestic partner or children of a domestic partner shall not constitute a special enrollment under this provision.

**SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)**

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

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

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

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

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

1. in the case of marriage, the 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)

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

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

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

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

OPEN ENROLLMENT

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

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

The effective date of coverage as the result of an open enrollment period will be the following January 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. 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:

TERMEmINATION OF EMPLOYEE COVERAGE

1. The date the employer terminates the Plan and offers no other group health plan.
2. The last day of the month in which the employee ceases to meet the eligibility requirements of the Plan.
3. The last day of the month in which employment terminates, as defined by the employer’s personnel policies.
4. The date the employee becomes a full-time, active member of the armed forces of any country.
5. The date the employee ceases to make any required contributions.

TERMEmINATION 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 remains eligible for the Plan, but elects to discontinue coverage, coverage may be extended for alternate recipients.
3. The last day of the month in which such person ceases to meet the eligibility requirements of the Plan.
4. The date the employee ceases to make any required contributions on the dependent’s behalf.
5. The date the dependent becomes a full-time, active member of the armed forces of any country.
6. The date the Plan discontinues dependent coverage for any and all dependents.

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.

SEVERANCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for employees and/or dependents, as the result of a severance package agreement for the length of time negotiated between the employee and employer.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An employee who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this Plan for up to twelve (12) weeks, except as noted under number 6. below, during any twelve (12) month period because of any of the following:

1. Birth of a child of the employee and in order to care for such child;
2. Placement of a child with the *employee* for adoption or foster care;

3. To care for the spouse, child, or parent of the *employee*, if such spouse, child, or parent has a serious health condition;

4. Because of a serious health condition that makes the *employee* unable to perform the functions of the position of such *employee*;

5. Because of any qualifying exigency (as determined by regulation) arising out of the fact that the spouse, child, or parent of the *employee* is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation; or

6. To care for a servicemember who is the spouse, child, parent, or next of kin to the *employee* for up to twenty-six (26) weeks during any twelve (12) month period. A covered servicemember means a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in an outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.

As used in this FMLA section, the terms "Outpatient Status" and "Serious Injury or Illness" shall have the following meanings:

*Outpatient Status*

With respect to a covered servicemember, outpatient status means the status of a member of the Armed Forces assigned to (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

*Serious Injury or Illness*

A serious injury or illness, in the case of a member of the Armed Forces, including a member of the National Guard or Reserves, means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of the servicemember’s office, grade, rank, or rating.

*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.
DEPENDENT CONTINUATION FOR RETIREES REACHING AGE 65

Medical care coverage for all dependents which is in force at the time of the retiree's loss of coverage due to reaching age 65, will continue until the earliest of the following dates:

1. The date the employer terminates the Plan and offers no other group health plan.
2. The last day of the month in which the dependent ceases to meet the eligibility requirements of the Plan.
3. The date the dependent becomes eligible for Medicare due to age.
4. The date the dependent becomes a full-time, active member of the armed forces of any country.
5. The date the dependent ceases to make any required contributions.

EMPLOYEE REINSTATEMENT

An employee who returns to work after a separation of service will be considered a new employee for purposes of eligibility and will be subject to all eligibility requirements, including all requirements relating to the effective date of coverage.

CERTIFICATES OF COVERAGE

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

In order to comply with federal regulations, this Plan includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. COBRA does not apply to domestic partners or the children of domestic partners. This means that a domestic partner or a child of a domestic partner is not eligible to continue group health plan coverage upon the termination of the domestic partnership, or upon the employee's death, reduction in hours or termination of employment. 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 this Plan or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date described in Termination of Coverage:

1. Death of the employee.

2. The employee's termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the Plan. This event is referred to below as an "18-Month Qualifying Event."

3. Divorce or legal separation from the employee.

4. The employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.

5. A dependent child no longer meets the eligibility requirements of the Plan.

6. The last day of leave under the Family and Medical Leave Act of 1993, or an earlier date on which the employer informs the employer that he or she will not be returning to work.

7. The call-up of an employee reservist to active duty.

8. A covered retiree and their covered dependents whose benefits were substantially eliminated within one (1) year of the employer filing for Chapter 11 bankruptcy.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered employee, or a child's loss of dependent status, the employee or dependent must submit a completed Qualifying Event Notification form to the plan administrator (or its designee) within sixty (60) days of the latest of:
   a. The date of the event;
   b. The date on which coverage under this Plan is or would be lost as a result of that event; or
   c. The date on which the employee or dependent is furnished with a copy of this Plan Document and Summary Plan Description.
A copy of the Qualifying Event Notification form is available from the plan administrator (or its designee). In addition, the employee or dependent may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

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

2. When eligibility for continuation of coverage results from any qualifying event under this Plan other than the ones described in Paragraph 1 above, the employer must notify the plan administrator (or its designee) not later than thirty (30) days after the date on which the employee or dependent loses coverage under the Plan due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the plan administrator (or its designee) will furnish the Election Notice to the employee or dependent.

3. In the event it is determined that an individual seeking continuation of coverage (or extension of continuation coverage) is not entitled to such coverage, the plan administrator (or its designee) will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame as applicable to the furnishing of the Election Notice.

4. In the event an Election Notice is furnished, the eligible employee or dependent has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was covered under the Plan on the day before the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the employee or dependent chooses to have continuation coverage, he must advise the plan administrator (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the plan administrator (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

   a. The date coverage under the Plan would otherwise end; or
   b. The date the person receives the Election Notice from the plan administrator (or its designee).

5. Within forty-five (45) days after the date the person notifies the plan administrator (or its designee) that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continuation coverage are to be made monthly, and are due in advance, on the first day each month.

COST OF COVERAGE

1. The Plan requires that covered persons pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the plan administrator (or its designee) by or before the first day of each month during the continuation period. The payment must be remitted on a timely basis in order to maintain the coverage in force.

2. For a person originally covered as an employee or as a spouse, the cost of coverage is the amount applicable to an employee if coverage is continued for himself alone. For a person originally covered as a child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an employee.
WHEN CONTINUATION COVERAGE BEGINS

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

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

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

EXTENSION OF CONTINUATION COVERAGE

1. In the event any of the following events occur during the period of continuation coverage resulting from an 18-Month Qualifying Event, it is possible for a dependent's continuation coverage to be extended:
   a. Death of the employee.
   b. Divorce or legal separation from the employee.
   c. The child's loss of dependent status.

   Written notice of such event must be provided by submitting a completed Additional Extension Event Notification form to the plan administrator (or its designee) within sixty (60) days of the latest of:
   (i.) The date of that event;
   (ii.) The date on which coverage under this Plan would be lost as a result of that event if the first qualifying event had not occurred; or
   (iii.) The date on which the employee or dependent is furnished with a copy of this Plan Document and Summary Plan Description.

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

   Only a person covered prior to the original qualifying event or a child born to or placed for adoption with a covered employee during a period of COBRA coverage may be eligible to continue coverage through an extension of continuation coverage as described above. Any other dependent acquired during continuation coverage is not eligible to extend continuation coverage as described above.

2. A person who loses coverage on account of an 18-Month Qualifying Event may extend the maximum period of continuation coverage from eighteen (18) months to up to twenty-nine (29) months in the event both of the following occur:
   a. That person (or another person who is entitled to continuation coverage on account of the same 18-Month Qualifying Event) is determined by the Social Security Administration, under Title II or Title XVI of the Social Security Act, to have been disabled before the sixtieth (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 this Plan as a result of the 18-Month Qualifying Event; or
(iv.) The date on which the person is furnished with a copy of this Plan Document and Summary Plan Description.

Should the disabled person fail to notify the plan administrator (or its designee) in writing within the time frame described above, the disabled person (and others entitled to disability extension on account of that person) will then be entitled to whatever period of continuation he or they would otherwise be entitled to, if any. The Plan may require that the individual pay one hundred and fifty percent (150%) of the cost of continuation coverage during the additional eleven (11) months of continuation coverage. In the event the Social Security Administration makes a final determination that the individual is no longer disabled, the individual must provide notice of that final determination no later than thirty (30) days after the later of:

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

END OF CONTINUATION

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

1. Eighteen (18) months (or twenty-nine (29) months if continuation coverage is extended due to certain disability status as described above) from the date continuation began because of an 18-Month Qualifying Event or the last day of leave under the Family and Medical Leave Act of 1993.

2. Twenty-four (24) months from the date continuation began because of the call-up to military duty.

3. Thirty-six (36) months from the date continuation began for dependents whose coverage ended because of the death of the employee, divorce or legal separation from the employee, or the child's loss of dependent status.

4. The end of the period for which contributions are paid if the covered person fails to make a payment by the date specified by the plan administrator (or its designee). In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under this Plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."

5. The date coverage under this Plan ends and the employer offers no other group health benefit plan. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

6. The date the covered person first becomes entitled, after the date of the covered person's original election of continuation coverage, to Medicare benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

7. The date the covered person first becomes covered under any other employer’s group health plan after the original date of the covered person's election of continuation coverage, but only if such group health plan does not have any exclusion or limitation that affects coverage of the covered person's pre-existing condition. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.
8. For the spouse or dependent child of a covered employee who becomes entitled to Medicare prior to the spouse’s or dependent’s election for continuation coverage, thirty-six (36) months from the date the covered employee becomes entitled to Medicare.

9. Retirees, and widows or widowers of retirees who died before substantial elimination of coverage within one (1) year of the employer's bankruptcy, are entitled to lifetime continuation coverage. However, if a retiree dies after substantial elimination of coverage within one (1) year of the employer's bankruptcy, the surviving spouse and dependent children may only elect an additional thirty-six (36) months of continuation coverage after the death.

SPECIAL RULES REGARDING NOTICES

1. Any notice required in connection with continuation coverage under this Plan must, at minimum, contain sufficient information so that the plan administrator (or its designee) is able to determine from such notice the employee and dependent(s) (if any), the qualifying event or disability, and the date on which the qualifying event occurred.

2. In connection with continuation coverage under this Plan, any notice required to be provided by any individual who is either the employee or a dependent with respect to the qualifying event may be provided by a representative acting on behalf of the employee or the dependent, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.

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

PRE-EXISTING CONDITIONS

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

MILITARY MOBILIZATION

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

When the leave is less than thirty-one (31) days, the employee and the employee's dependent may not be required to pay more than the employee's share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the plan administrator (or its designee) may require the employee and the employee's dependent to pay no more than one hundred and two percent (102%) of the full contribution.
The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or

2. A period beginning on the day that the leave began and ending on the day after the employee fails to return to employment within the time allowed.

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

**PLAN CONTACT INFORMATION**

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

**ADDRESS CHANGES**

In order to help ensure the appropriate protection of rights and benefits under this Plan, covered persons should keep the plan administrator (or its designee) informed of any changes to their current addresses.
MEDICAL 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. A claim form is to be completed for each covered family member at the beginning of the calendar year and for each claim involving an injury. Appropriate claim forms are available from the Human Resource Department.

2. Claims should be submitted to the Preferred Provider Organization (PPO), which is identified on the employee identification card and shown below:

   Preferred Healthcare Systems, Inc.
   P.O. Box 1015
   Duncansville, PA  16635

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

3. 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.
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the accident, injury or illness being treated.

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

4. All claims not submitted within twelve (12) months from the date the services were rendered will not be a covered expense and will be denied.

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

NOTICE OF AUTHORIZED REPRESENTATIVE

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

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

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

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

TIME FRAME FOR BENEFIT DETERMINATION

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

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

Failure to respond in a timely and complete manner will result in the denial of benefit payment.

NOTICE OF BENEFIT DENIAL

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

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

1. The specific reasons for the denial.
2. Reference to the Plan provisions on which the denial is based.
3. A description of any additional material or information needed and an explanation of why such material or information is necessary.
4. A description of the Plan’s claim review procedure and applicable time limits.
5. A statement that if the covered person’s appeal (Refer to Appealing a Denied Post-Service Claim below) is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
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.
APPELLING A DENIED POST-SERVICE CLAIM

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

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

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

1. The covered person has the right to submit documents, information and comments.
2. The covered person has the right to access, free of charge, relevant information to the claim for benefits.
3. The review takes into account all information submitted by the covered person, even if it was not considered in the initial benefit determination.
4. The review by the named fiduciary will not afford deference to the original denial.
5. The named fiduciary will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
6. If original denial was, in whole or in part, based on medical judgment:
   a. The named fiduciary will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment; and
   b. The professional provider utilized by the named fiduciary will be neither:
      (i.) An individual who was consulted in connection with the original denial of the claim, nor
      (ii.) A subordinate of any other professional provider who was consulted in connection with the original denial.
7. If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON APPEAL

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

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

1. The specific reasons for the denial.
2. Reference to specific Plan provisions on which the denial is based.
3. A statement that the covered person has the right to access, free of charge, relevant information to the claim for benefits.
4. A statement that if the covered person’s appeal is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
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:

1-800-480-6658

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

1. Employee’s name, address, phone number and CoreSource Member Identification Number.
2. Employer’s name.
3. If not the employee, the patient’s name, address, phone number.
4. Admitting physician’s name and phone number.
5. Name of facility, home health care agency or hospice.
6. Date of admission or proposed date of admission.
7. Condition for which patient is being admitted.
Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

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

If the covered person (or authorized representative) fails to contact the Health Care Management Organization prior to the hospitalization and within the timelines detailed above, the amount of benefits payable for covered expenses incurred shall be reduced by $150 for nonpreferred providers only, for the purpose of determining benefits payable. If the Health Care Management Organization declines to grant the full pre-certification requested, benefits for days not certified as medically necessary by the Health Care Management Organization shall be denied. (Refer to Post-Service Claim Procedure discussion above.)

NOTICE OF AUTHORIZED REPRESENTATIVE

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

TIME FRAME FOR PRE-SERVICE CLAIM DETERMINATION

1. In the event the Plan receives from the covered person (or authorized representative) a communication that fails to follow the pre-certification procedure as described above but communicates at least the name of the covered person, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the covered person (or the authorized representative) will be orally notified (and in writing if requested), within five (5) calendar days of the failure of the proper procedure to be followed.

2. After a completed pre-certification request for non-urgent care has been submitted to the Plan, and if no additional information is required, the Plan will generally complete its determination of the claim within a reasonable period of time, but no later than fifteen (15) calendar days from receipt of the request.

3. After a pre-certification request for non-urgent care has been submitted to the Plan, and if an extension of time to make a decision is necessary due to circumstances beyond the control of the Plan, the Plan will, within fifteen (15) calendar days from receipt of the request, provide the covered person (or authorized representative) with a notice detailing the circumstances and the date by which the Plan expects to render a decision. If the circumstances include a failure to submit necessary information, the notice will specifically describe the needed information. The covered person will have forty-five (45) calendar days to provide the information requested, and the Plan will complete its determination of the claim no later than fifteen (15) calendar days after receipt by the Plan of the requested information. Failure to respond in a timely and complete manner will result in a denial.
CONCURRENT CARE CLAIMS

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

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

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

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

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

NOTICE OF PRE-SERVICE CLAIM DENIAL

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

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

1. The specific reasons for the denial.
2. Reference to the Plan provisions on which the denial is based.
3. A description of any additional material or information needed and an explanation of why such material or information is necessary.
4. A description of the Plan’s claim review procedure and applicable time limits.
5. A statement that if the **covered person**’s appeal (Refer to *Appealing a Denied Pre-Service Claim* below) is denied, the **covered person** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

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

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

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

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

1. The **covered person** has the right to submit documents, information and comments.
2. The **covered person** has the right to access, free of charge, **relevant information** to the claim for benefits.
3. The review takes into account all information submitted by the **covered person**, even if it was not considered in the initial benefit determination.
4. The review by the **named fiduciary** will not afford deference to the original denial.
5. The **named fiduciary** will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
6. If original denial was, in whole or in part, based on medical judgment:
   a. The **named fiduciary** will consult with a **professional provider** who has appropriate training and experience in the field involving the medical judgment.
   b. The **professional provider** utilized by the **named fiduciary** will be neither:
      (i.) An individual who was consulted in connection with the original denial of the claim, nor
      (ii.) A subordinate of any other **professional provider** who was consulted in connection with the original denial.
7. If requested, the **named fiduciary** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

### NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL

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

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

1. The specific reasons for the denial.
2. Reference to specific **Plan** provisions on which the denial is based.
3. A statement that the covered person has the right to access, free of charge, relevant information to the claim for benefits.

4. A statement that if the covered person’s appeal is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

5. A statement that the covered person has the right to access, free of charge, information about the voluntary appeal process.

6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If the denial was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the plan administrator (or its designee) will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

SECOND LEVEL VOLUNTARY APPEAL

The Health Care Management Organization, upon request by the covered person (or authorized representative) following a pre-service determination on appeal, will conduct a second level voluntary appeal. This appeal is comprised of a panel of three professional providers that were not consulted in connection with the original pre-service denial. The covered person’s decision as to whether to submit a previously denied appeal to the voluntary appeal process will have no effect on the covered person’s rights to any other benefits under the Plan. There are no fees or costs imposed as a condition to use of the voluntary appeal process.

Upon receipt of the request to conduct a voluntary appeal, a determination will be made within thirty (30) calendar days. Notification of the outcome of the review will be communicated verbally and in writing.

With respect to pre-service claims, the Plan agrees not to later assert a defense of failure to exhaust available administrative remedies against a covered person who chooses not to make use of the voluntary appeal process.

With respect to pre-service claims, the Plan agrees that any statute of limitations or other defense based on timelines is tolled while the dispute is under submission to the voluntary appeal process.

Upon written request, more information about the voluntary appeal process is available, free of charge, from the Health Care Management Organization.

CASE MANAGEMENT

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

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

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

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

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

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

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

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

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

DEFINITIONS APPLICABLE TO THIS PROVISION

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

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

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

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

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

1. Group insurance or any other arrangement for coverage for covered persons in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;

2. Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

5. Any coverage under a government program and any coverage required or provided by any statute;

6. Group automobile insurance;

7. Individual automobile insurance coverage;
8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

9. Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;

10. Labor/management 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 paid under this Plan may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expenses.

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

**ORDER OF BENEFIT DETERMINATION**

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

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

2. **Member/Dependent**
   The plan which covers the claimant directly pays before a plan that covers the claimant as a dependent.

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

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

   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.

   b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.

5. **Active/Inactive**
   The plan covering a person as an active (not laid off or retired) employee or as that person's dependent pays first. The plan covering that person as a laid off or retired employee, or as that person's dependent pays second.
6. **Limited Continuation of Coverage**
   If a person is covered under another group health plan, but is also covered under this Plan for continuation of coverage due to the Other Plan's limitation for pre-existing conditions or exclusions, the Other Plan shall be primary.

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

**COORDINATION WITH MEDICARE**

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

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

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

3. If the **employee** and/or **dependent** are also enrolled in Medicare (due to age or disability), this Plan shall pay as the primary plan. If, however, the Medicare enrollment is due to end stage renal disease, the Plan's primary payment obligation will end at the end of the thirty (30) month "coordination period" as provided in Medicare law and regulations.

4. Notwithstanding Paragraphs 1 to 3 above, if the **employer** (including certain affiliated entities that are considered the same employer for this purpose) has fewer than one hundred (100) **employees**, when a covered **dependent** becomes entitled to Medicare coverage due to total disability, as determined by the Social Security Administration, and the **employee** is actively-at-work, Medicare will pay as the primary payer for claims of the **dependent** and this Plan will pay secondary.

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

6. For a **retiree** eligible for Medicare due to age, Medicare shall be the primary payor and this Plan shall be secondary.

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

**LIMITATIONS ON PAYMENTS**

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

**RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**

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

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

**AUTOMOBILE ACCIDENT BENEFITS**

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

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

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

1. In the event a covered person incurs medical expenses as a result of injuries sustained in an automobile accident while “covered by an automobile insurance policy,” as an operator of the vehicle, as a passenger, or as a pedestrian, benefits will be further limited to medical expenses, that would in no event be payable under the automobile insurance; provided however that benefits payable due to a required deductible under the automobile insurance policy will be paid by the Plan up to the amount equal to that deductible.

2. For the purposes of this section the following people are deemed “covered by an automobile insurance policy.”
   a. An owner or principal named insured individual under such policy.
   b. A family member of an insured person for whom coverage is provided under the terms and conditions of the automobile insurance policy.
   c. Any other person who, except for the existence of the Plan, would be eligible for medical expense benefits under an automobile insurance policy.

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

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

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

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

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

2. Equitable Lien and other Equitable Remedies. The Plan shall have an equitable lien against any rights the covered person may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to any right to payment from workers’ compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers’ compensation insurers or the employer will be deemed to mean that such a determination has been made.

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

This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court’s decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the Plan concerning subrogation, equitable liens and other equitable remedies are also intended to supercede the applicability of the federal common law doctrines commonly referred to as the “make whole” rule and the “common fund” rule.
3. **Assisting in Plan’s Reimbursement Activities.** The **covered person** has an obligation to assist the **Plan** to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the **covered person**, and to provide the **Plan** with any information concerning the **covered person’s** other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the **covered person**. The **covered person** is required to (a) cooperate fully in the **Plan’s** (or any **Plan** fiduciary’s) enforcement of the terms of the **Plan**, including the exercise of the **Plan’s** right to subrogation and reimbursement, whether against the **covered person** or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the **Plan** as a co-payee for the amount of the Reimbursable Payments and notifying the **Plan**), (c) sign any document deemed by the **plan administrator** to be relevant to protecting the **Plan’s** subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term “information” includes any documents, insurance policies, police reports, or any reasonable request by the **plan administrator** or **claims processor** to enforce the **Plan’s** rights.

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

ADMINISTRATION OF THE PLAN

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

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

APPLICABLE LAW

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

ASSIGNMENT

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

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

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

BENEFITS NOT TRANSFERABLE

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

CLERICAL ERROR

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

CONFORMITY WITH STATUTE(S)

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

The original effective date of this Plan was January 1, 2003. The effective date of the modifications contained herein is January 1, 2011.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

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

INCAPACITY

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

INCONTESTABILITY

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

LEGAL ACTIONS

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

LIMITS ON LIABILITY

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

LOST DISTRIBUTVEES

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.

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 this Plan null and void.

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

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

PLAN IS NOT A CONTRACT

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

PLAN MODIFICATION AND AMENDMENT

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

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

PLAN TERMINATION

The employer reserves the right to terminate the Plan at any time. Upon termination, the rights of the covered persons to benefits are limited to claims incurred up to the date of termination. Any termination of the Plan will be communicated to the covered persons.
Upon termination of this Plan, all claims incurred prior to termination, but not submitted to either the employer or claims processor within three (3) months of the effective date of termination of this Plan, will be excluded from any benefit consideration.
**PRONOUNS**

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

**RECOVERY FOR OVERPAYMENT**

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

**STATUS CHANGE**

If an *employee* or *dependent* has a status change while covered under this *Plan* (*i.e.*, *dependent* to *employee*, COBRA to active) and no interruption in coverage has occurred, the *Plan* will provide continuous coverage with respect to any deductible(s), *coinsurance* and *maximum benefit*.

**TIME EFFECTIVE**

The effective time with respect to any dates used in the *Plan* shall be 12:01 a.m. as may be legally in effect at the address of the *plan administrator*.

**WORKERS’ COMPENSATION NOT AFFECTED**

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

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

DISCLOSURE BY PLAN TO PLAN SPONSOR

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

1. Disclose protected health information to the plan sponsor.

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

USE AND DISCLOSURE BY PLAN SPONSOR

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

OBLIGATIONS OF PLAN SPONSOR

The plan sponsor shall have the following obligations:

1. Ensure that:
   a. Any agents (including a subcontractor) to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information; and
   b. Adequate separation between the Plan and the plan sponsor is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(iii).

2. Not use or further disclose protected health information received from the Plan, other than as permitted or required by the Plan documents or as required by law.

3. Not use or disclose protected health information received from the Plan:
   a. For employment-related actions and decisions; or
   b. In connection with any other benefit or employee benefit plan of the plan sponsor.

4. Report to the Plan any use or disclosure of the protected health information received from the Plan that is inconsistent with the use or disclosure provided for of which it becomes aware.

5. Make available protected health information received from the Plan, as and to the extent required by the privacy rule:
   a. For access to the individual;
   b. For amendment and incorporate any amendments to protected health information received from the Plan; and
   c. To provide an accounting of disclosures.

6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the privacy rule.
7. Return or destroy all protected health information received from the Plan that the plan sponsor still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the Plan was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

8. Provide protected health information only to those individuals, under the control of the plan sponsor who perform administrative functions for the Plan; (i.e., eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for Plan administrative functions nor to release protected health information to an unauthorized individual.

9. Provide protected health information only to those entities required to receive the information in order to maintain the Plan (i.e., claim administrator, case management vendor, pharmacy benefit manager, claim subrogation, vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the Plan).

10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.

11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the plan sponsor on behalf of the Plan. Specifically, such safeguarding entails an obligation to:
   a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;
   b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
   c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
   d. Report to the Plan any security incident of which it becomes aware.

EXCEPTIONS

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

1. Disclose summary health information to the plan sponsor:
   a. If the plan sponsor requests it for the purpose of:
      (i.) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
      (ii.) Modifying, amending, or terminating the Plan;

2. Disclose to the plan sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan;

3. Use or disclose protected health information:
   a. With (and consistent with) a valid authorization obtained in accordance with the privacy rule;
   b. To carry out treatment, payment, or health care operations in accordance with the privacy rule; or
   c. As otherwise permitted or required by the privacy rule.
DEFINITIONS

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

**Accident**

An unforeseen event resulting in *injury*.

**Alternate Recipient**

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

**Ambulatory Surgical Facility**

A *facility* provider with an organized staff of *physicians* which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., or by *Medicare*; or that has a contract with the *Preferred Provider Organization* as a *preferred provider*. An *ambulatory surgical facility* is a *facility* that:

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

**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 *Summary Plan Description* (SPD) section of this document.
Close Relative

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

Coinsurance

The benefit percentage of covered expenses payable by the Plan for benefits that are provided under the Plan. The coinsurance is applied to covered expenses after the deductible(s) have been met, if applicable.

Complications of Pregnancy

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

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

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

Concurrent Care

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

Confinement

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

Copay

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

Cosmetic Surgery

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

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

Covered Person

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

Custodial Care

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

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

Customary and Reasonable Amount

Any negotiated fee (where the provider has contracted to accept such fee as payment in full for covered expenses of the Plan) assessed for services, supplies or treatment by a nonpreferred provider, or a fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is incurred and is comparable in severity and nature to the illness or injury. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. Except as to negotiated fees, the customary and reasonable amount is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges. The percentage applicable to this Plan is 85% and is applied to CPT codes or HIAA Code Analysis using MDR or HIAA tables.

Dentist

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

Dependent

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

Domestic Partner

A domestic partner is a same or opposite sex partner of an employee who:

1. Is engaged in a committed relationship of mutual caring and support with the employee and is jointly responsible with the employee for each others’ common welfare and living expenses such as food, shelter and medical expenses and agrees that they share financial obligations; and
2. Is at least eighteen (18) years of age and mentally competent to consent to a contract; and
3. Is the sole domestic partner of the employee and intends to remain so indefinitely; and
4. Is not married to or legally separate from anyone else; and
5. Is not related to the employee by blood to a degree of closeness that would prohibit legal marriage in the state in which they reside; and
6. Has been residing with the employee continuously for at least six (6) months immediately prior to the date of the Affidavit of Domestic Partnership, is currently living with the employee in the same residence and intends to do so indefinitely; and
7. Has not had a different domestic partner in the last six (6) months, unless the previous domestic partnership terminated by death; and
8. Is not in a domestic partnership with the employee solely for the purpose of obtaining benefits coverage.

In addition to the above provisions, the employee and his/her domestic partner must possess proof of at least three (3) of the following:

1. Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
2. Common ownership of a motor vehicle;
3. Driver’s license listing a common address;
4. Proof of joint bank accounts or credit accounts;
5. Proof of designation as the primary beneficiary designation under a partner’s will; or
6. Assignment of a durable property power of attorney or health care power of attorney.

Upon termination of a domestic partnership, the employee is obligated to notify the company in writing within thirty (30) days. An employee cannot elect to cover another domestic partner under the company health insurance plans or other company benefits for at least six (6) months unless a previous domestic partnership terminated by death.

**Durable Medical Equipment**

Medical equipment which:

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

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

**Effective Date**

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

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

1. Placing the covered person’s life (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
2. Causing other serious medical consequences, or
3. Causing serious impairment to bodily functions, or
4. Causing serious dysfunction of any bodily organ or part.

Employee

A person directly involved in the regular business of and compensated for services, as reported on the individual’s annual W-2 form, by the employer, who is regularly scheduled to work not less than thirty-two (32) hours per work week on a full-time status basis.

Employer

The employer is Juniata College.

Enrollment Date

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

Experimental/Investigational

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

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

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, was not reviewed and approved by the treating facility’s institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
3. If “reliable evidence” shows that the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials, is in the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or

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

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

Extended Care Facility

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

1. It is licensed to provide, and is engaged in providing, on an inpatient basis, for persons convalescing from illness or injury, professional nursing services, and physical restoration services to assist covered persons to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse.

2. Its services are provided for compensation from its covered persons and under the full-time supervision of a physician or Registered Nurse.

3. It provides twenty-four (24) hour-a-day nursing services.

4. It maintains a complete medical record on each covered person.

5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of mental and nervous disorders.

6. It is approved and licensed by Medicare.

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

Facility

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

Full-time

Employees who are regularly scheduled to work not less than thirty-two (32) hours per work week.

Generic Drug

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

Health Care Management

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

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

Home Health Aide Services

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

Home Health Care

Includes the following services: private duty nursing, 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.

**Immediate Care Center**

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

1. a board-certified physician, a Registered Nurse (RN) and a registered x-ray technician in attendance at all times;

2. has x-ray and laboratory equipment and life support systems.

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

**Incurred or Incurred Date**

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

**Injury**

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

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

Intensive Care

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

Intensive Care Unit

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

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

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

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

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

1. The maximum amount paid by this Plan for any one covered person during the entire time he is covered by this Plan.
2. The maximum amount paid by this Plan for any one covered person for a particular covered expense. The maximum amount can be for:
   a. The entire time the covered person is covered under this Plan, or
   b. A specified period of time, such as a calendar year.
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.

Medically Necessary (or Medical Necessity)

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

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the covered person’s illness or injury and which could not have been omitted without adversely affecting the covered person’s condition or the quality of the care rendered; and
2. Supplied or performed in accordance with current standards of medical practice within the United States; and

3. Not primarily for the convenience of the covered person or the covered person’s family or professional provider; and

4. Is an appropriate supply or level of service that safely can be provided; and

5. Is recommended or approved by the attending professional provider.

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

Medicare

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

Mental and Nervous Disorder

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

Named Fiduciary for Post-Service Claim Appeals

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

Named Fiduciary for Pre-Service Claim Appeals

Medical Claims:
CoreSource, Inc.
P.O. Box 2920
Clinton, Iowa 52733-2920

Prescription Drug Claims:
Caremark
211 Commerce Street, Suite 800
Nashville, TN 37201

Negotiated Rate

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

Nonparticipating Pharmacy

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

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

Nurse

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

Outpatient

A covered person shall be considered to be an outpatient if he is treated at:
1. A hospital as other than an inpatient;
2. A physician's office, laboratory or x-ray facility; or
3. An ambulatory surgical facility; 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.

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" refers to the benefits and provisions for payment of same as described herein. The Plan is the Juniata College Employee 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 Juniata College.

**Plan Year End**

The plan year end is December 31st.

**Preferred Provider**

A physician, hospital or other health care provider who has an agreement in effect with the Preferred Provider Organization at the time services are rendered.

**Preferred Provider Organization**

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

**Pregnancy**

The physical state which results in childbirth or miscarriage.

**Privacy Rule**


**Professional Provider**

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

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

Qualified Prescriber

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

Reconstructive Surgery

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

Relevant Information

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

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

Required By Law

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

Retiree

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

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

**Routine Examination**

A comprehensive history and physical examination which would include services as defined in *Medical Expense Benefit, Routine Preventive Care*.

**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.

**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.

**Well Child Care**

Preventive care rendered to *dependent* children through the age of eighteen (18).