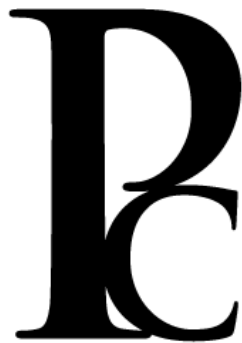


**SELF-FUNDED
PLAN DOCUMENT
FOR**



PRESBYTERIAN COLLEGE

GROUP MEDICAL PLAN

**Restated
Effective Date: October 1, 2009**

TABLE OF CONTENTS

ABOUT YOUR PLAN	1
PRIOR APPROVAL OF TREATMENT.....	4
CLAIM DETERMINATIONS AND APPEALS.....	7
CASE MANAGEMENT.....	9
EMPLOYEE SELF-AUDIT PROGRAM.....	10
MEDICAL SCHEDULE OF BENEFITS	11
PRESCRIPTION DRUG BENEFITS.....	14
COVERED MEDICAL EXPENSES	15
HUMAN ORGAN OR TISSUE TRANSPLANT BENEFITS.....	20
EXCLUSIONS AND LIMITATIONS	22
ELIGIBILITY FOR COVERAGE.....	26
EFFECTIVE DATE OF COVERAGE	28
PRE-EXISTING CONDITION PROVISIONS.....	30
TERMINATION OF COVERAGE	31
WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998	32
FAMILY AND MEDICAL LEAVE ACT (“FMLA”)	32
UNIFORMED SERVICES EMPLOYMENT and RE-EMPLOYMENT RIGHTS ACT (USERRA).....	33
SUBROGATION / RIGHT OF REIMBURSEMENT.....	34
WORKERS COMPENSATION PROVISION.....	35
COORDINATION OF BENEFITS	36
PRIVACY & SECURITY OF PROTECTED HEALTH INFORMATION.....	39
GENERAL INFORMATION	41
DEFINITIONS.....	44
INDEX	57

As you read through this Plan Document, you will see capitalized terms. Capitalized terms have a special meaning when used in this Plan Document. The meanings of capitalized terms are found in the Definitions section.

ABOUT YOUR PLAN

Because of the dramatic increase in the cost of medical care, group health plans encourage and reward those covered individuals who are selective in their purchase of medical services.

Your Plan Sponsor expects and encourages you to review this booklet which describes your health plan. Be a selective medical consumer and assume the major role in keeping the cost of medical services at a minimum.

Your Employer has established a comprehensive group health plan (“Plan”) for its employees. In connection with the Plan, your Employer has retained the services of *Planned Administrators, Incorporated* (a third party administrator) to process and pay health claims and to provide consulting services in connection with the operation of this Plan of Benefits. *Planned Administrators, Incorporated* (PAI) is also referred to as the Plan Supervisor and is located in Columbia, South Carolina. PAI has contracted with the **Blue Cross and Blue Shield of South Carolina Preferred Blue and Private Healthcare System** networks as the Preferred Provider Organizations (“PPOs”).

You will receive maximum benefits when you use Providers who participate in the PPO (“PPO Providers” is explained further below) and when you obtain authorization (when required) for services. You will pay more if you do not use PPO Providers or if you do not obtain prior authorization (unless an emergency). The following information explains what a PPO Provider is and how you obtain authorization from the Medical Services Department for services or supplies covered by your health plan.

It is your responsibility to ensure that your Provider is a PPO Provider. You should verify your Provider’s status before services are rendered. To verify whether your Provider is a PPO Provider you may:

- Ask the Provider if they participate in the PPO.
- If available, review the appropriate website for Provider information (*)
- Call Planned Administrators, Inc. (PAI) (*)

The methods of verifying PPO participation that have an asterisk (*) may have timing differences between when a Provider is participating in the PPO or terminating from the PPO. The preferable method of obtaining the most correct information is to ask your Provider.

For South Carolina Employees, the Blue Cross and Blue Shield Preferred Blue Network is the PPO for this plan. Pre-Approval is required for out-of-network hospital admission 1-888-376-6544 (page 5). Private Healthcare System (PHCS) Travel will be the PPO for Employees traveling out of state.

PPO Providers including Hospitals, Skilled Nursing Facilities, home health agencies, hospices, doctors and other Providers of medical services and supplies (as listed in the Definitions section) have a written agreement with the PPO. Under their agreement with the PPO, PPO Providers will do the following:

- File all claims for Benefits or supplies with your Plan Supervisor;
- Ask you to pay only the Deductible, per occurrence Co-payments and Coinsurance amounts, if any for Benefits;
- Accept the preferred allowance as payment in full for Covered Expenses; and
- Make sure that all necessary approvals are obtained from the Medical Services Department.

Non-PPO Providers including Hospitals, Skilled Nursing Facilities, home health agencies, hospices, doctors and other Providers of medical services and supplies that are not under contract with the PPO. Non-PPO Providers can bill you their total charge. They may ask you to pay the total amount of their charges at the time you receive services or supplies, to file your own claims, and you will need to obtain any necessary approvals for benefits to be paid. In addition to Deductibles and Coinsurance, you are responsible for the difference between the Non-PPO Provider’s charge and the Allowed Amount for Covered Expenses.

Although Benefits are typically reduced when you use a Non-PPO Provider, Benefits provided by a Non-PPO Provider will be covered at the PPO Provider level under the following circumstances:

- In the event treatment is for an Emergency Medical Condition as defined in this Plan of Benefits and PPO Provider care is not available;
- For Dependents who are Full-time Students living out-of-state;
- For treatment by a specialist when a PPO Provider specialist is not available;
- For Non-PPO Provider Ancillary Services rendered in a PPO Provider Hospital.

Customer Service

Your Plan Supervisor is committed to helping you understand your coverage and obtain maximum benefits on your claims. If you have questions about your coverage, you may call or write your Plan Supervisor at the following:

Planned Administrators, Inc.
Attn: Claims
P.O. Box 6927
Columbia, SC 29260
1-800-768-4375
www.paisc.com

How To File Claims For Services You Have Already Received

If you receive healthcare services or supplies from a PPO Provider, the PPO Provider should file your claims for you.

If you receive healthcare services or supplies from a Non-PPO Provider or non-Participating Network Pharmacy, you will have to file your own claims. When filing your own claims, here are some things you will need:

1. **Claim Form for each patient.** You can get these forms from the Member Services Center or you may print a form off of your TPA website at www.paisc.com.
2. **Copies of your Itemized Bills from the Providers.** These bills should include:
 - Provider's name and address
 - Patient's name and date of birth
 - Employee's ID number
 - Description and cost of each service
 - Date that each service took place
 - Description of the Illness or Injury (diagnosis)

To file a claim you must complete the front of each claim form and attach the itemized bills to it. If you (or your dependent for claims filed for your dependent's care) have other insurance that has already paid some or all of the claims, be sure to attach a copy of the other insurance plan's Explanation of Benefits (EOB) notice. This will help prevent a delay of your claims processing.

Before you submit your claims, the Plan Supervisor suggests you make copies of all claim forms and itemized bills for your records since the Plan Supervisor cannot return them to you.

Once you have completed the claim form and attached the itemized bills, send your claims to Planned Administrators, Inc. at the address found in the *Customer Service* section above.

Time Limits to File a Claim

Non-Preferred (Non-PPO) claims must be received no later than ninety (90) days from the end of the Benefit Year in which services were received. Preferred (PPO) claims must be filed no later than twelve (12) months from the incurred dates of service in which you or your Dependents receive the medical services or supplies. Exception may be made where an Employee shows they were not legally competent to file the claim.

Authorized Representatives and Representatives designated under HIPAA

Unless expressly permitted by law, you and your dependent's Protected Health Information generally cannot be released to any other person without your or your dependent's (where they are over the age of 18) consent. However, there are instances when you may want someone to discuss your Protected Health Information with PAI, or receive an explanation of benefits, etc. to manage your care. In order to comply with applicable laws and also to comply with your request, you must sign a written authorization form. To obtain a copy of the form, please visit the PAI website at www.paisc.com, go to member services and then select "forms". You can print this form and mail to the PAI address or you can call 1(800) 768-4375 for a copy of the form.

A Provider may be considered a Participant's authorized representative without a specific designation by the Participant when the claim request is for an Urgent Care Claim. A Provider may be a Participant's authorized representative with regard to non-Urgent Care claims only when the Participant gives the Plan Supervisor or the Provider a specific designation, in writing in a format that is reasonably acceptable to the Plan to act as an authorized representative. All information and notifications will continue to be directed to the Participant unless the Participant gives contrary directions.

PRIOR APPROVAL OF TREATMENT

To receive the maximum Benefits under the Plan, certain types of services and equipment and all Admissions require approval prior to your receipt in order to be covered under the Plan. The Medical Review Department or Companion Benefits Alternatives, Inc. ("CBA") must give advance approval for the services and equipment that require approval and for all Admissions.

Items requiring approval are listed on the Schedule of Benefits.

Where to Call for Approval

For prior approval for medical services or supplies, call the Blue Cross and Blue Shield of South Carolina Medical Review Department at 1(800) 652-3076.

For prior approval for Mental and Nervous Treatment and treatment for Substance Abuse, call CBA at 1(800) 868-1032. CBA is a Mental Health and Substance Abuse subsidiary of Blue Cross and Blue Shield of South Carolina.

If you need approval, be sure to call the Medical Review Department or CBA. Please do not call the PAI customer service department. A customer services representative cannot give approval.

These numbers are also on the back of your ID card. Be sure to keep your card with you at all times since you never know when you may need to reach us.

When you call for review and approval, you will talk with a medical professional. He or she will ask you for the following information:

- Your name and ID number.
- The Employer.
- The patient's name and relationship to you.
- The Provider's name, address and phone number.
- If applicable, the Hospital or Skilled Nursing Facility's name, address and phone number.
- The reason the requested service, supply or admission is necessary.

After careful review, your Physician and Hospital will be notified whether the service, supply or admission is approved as Medically Necessary and how long the approval is valid.

Approval means only that the Medical Review Department or CBA has agreed that a service is Medically Necessary for treatment of the Participant's condition. However, **approval is not a guarantee or verification of Benefits. Benefits are subject to eligibility, all Pre-existing Condition Limitations and all other Plan limitations and exclusions. The final determination will be made when the Plan Supervisor processes your claim(s).** If you have any questions about whether a certain service will be covered, please contact PAI.

If you or a Dependent is undergoing a human organ and/or tissue transplant, written approval must be obtained in advance [and the procedure must be done at a Provider that the Plan Supervisor designates]. **If the Plan Supervisor does not pre-approve these services in writing [or they are not done by a Provider the Plan Supervisor designates], then your Plan will not pay any Benefits.**

If your Physician recommends services and supplies for you or your Dependent for any reason, make sure you tell your Physician that your health insurance plan requires advance approval. Preferred Providers will be familiar with this requirement and will get the necessary approvals.

If you or your Dependent does not use a Preferred Provider, it is your responsibility to obtain approval before receiving the service, supply or being admitted. If you do not get prior approval, your services may not be covered.

Please note that if your claim for services or Benefits is denied, you may request further review under the guidelines set out in the *Appeal Procedures* section of this booklet. Remember that a denial of a Prior Approval is a denied claim for purposes of an appeal.

Types of Approval

There are five different types of approval:

1. Preadmission
2. Emergency Admission
3. Concurrent Care
4. Preauthorization Review
5. Preauthorization for Mental and Nervous Treatment and treatment for Substance Abuse

Here are more details about each one:

Preadmission— Before you or a dependent are admitted to a Hospital or Skilled Nursing Facility, preadmission approval must be obtained. If you have just had a baby, approval must be obtained within 24 hours of your discharge if your Newborn is sick and must stay in the Hospital.

If approval is not obtained, or if the Admission is not approved and you or your dependent is still admitted, the Plan Supervisor will not pay Benefits for any part of the room and board charges for a Preferred Hospital or Skilled Nursing Facility and they must write off the non-paid amount. They cannot bill you for this amount. However, approval for Admission to a Non-PPO Provider facility is your responsibility and you will be responsible for the first \$200 in payable charges if approval is not obtained.

Emergency Admission— If you or one of your Dependents experiences an emergency Illness or Injury, go to the nearest emergency room right away or call 911 for help. The Plan Supervisor does not expect you to wait for approval before you go to the Hospital.

However, you must seek approval within 24 hours of the emergency Admission, or by 5 p.m. of the next working day following the Admission. (Exceptions may be made for reasons beyond your control.)

If emergency Admission approval is not obtained within 24 hours or by the next working day, the Plan Supervisor will not pay Benefits for any part of the room and board charges for a Preferred Hospital or Skilled Nursing Facility and they must write off the non-paid amount. They cannot bill you for this amount. However, approval for emergency Admission to a Non-PPO Provider facility is your responsibility and you will be responsible for the first \$200 in payable charges if approval is not obtained.

Concurrent Care— It is possible that you or a Dependent may have to remain in the Hospital or Skilled Nursing Facility for a period longer than originally approved. If this is the case, concurrent care approval must be obtained.

If concurrent care approval is not obtained, or if the concurrent care is not approved, but you or your Dependent remains in the Hospital or Skilled Nursing Facility, the Plan Supervisor will not pay Benefits for any part of the room and board charges for the period of the continued stay. If a Preferred Blue Hospital or Skilled Nursing Facility does not get approval, they must write off the penalty non-paid amount. They cannot bill you for this amount. However, approval for emergency Admission to a Non-PPO Provider facility is your responsibility and you will be responsible for the first \$200 in payable charges if approval is not obtained.

Preauthorization— A number of services and medical procedures require Preauthorization. These are listed on the Schedule of Benefits:

Without advance approval, the Plan will not pay Benefits for any part of the charges for Home Health Care, Hospice Care or Durable Medical Equipment when the purchase price or rental cost is \$100 or more. If written advance approval is not obtained for human organ and/or tissue transplants [or the service is not done by a Provider the Plan Supervisor designates], your Plan will not pay Benefits. If a Preferred Blue Provider does not get Preauthorization, it cannot bill you for these charges.

For more information about services and supplies that require Preauthorization Review, please see the *Covered Expenses* section. If you have specific questions, please call or write PAI.

Preauthorization for Mental and Nervous Treatment and treatment for Substance Abuse – CBA must pre-approve any inpatient treatment for Mental and Nervous Treatment and treatment for Substance Abuse care.

Out-of-area Emergency Provision

If you or a Dependent receives care for an Emergency Medical Condition from a Non-Preferred Provider, the Plan will pay for Benefits at a PPO Provider level of benefits if you meet all of these conditions:

- You were traveling for reasons other than seeking medical care when the Emergency Medical Condition occurred.
- You were treated for an Accidental Injury or new Emergency Medical Condition.

Benefits under this provision are subject to the Deductibles or Co-payments, Coinsurance and all Plan of Benefits maximums, limits and exclusions.

If you have claims that meet all of these conditions, write or call the PAI customer service department. The Plan Supervisor will review your claims to determine if the Plan Supervisor can provide additional Benefits.

CLAIM DETERMINATIONS AND APPEALS

CLAIM DETERMINATION

There are generally two types of claims. These are: (1) Pre-service Claims, which includes Urgent Care Claims and Concurrent Care Claims and (2) Post-service Claims. The time frames allowed for the Group Health Plan to provide a determination for each of these types of claims are listed below:

1. **Pre-service Claim** – A determination for most Pre-service Claims (other than Urgent Care Claims and Concurrent Care Claims as set forth below) will be provided to you (in writing or in electronic form) within 15 calendar days of our receipt of the claim.

An extension of 15 calendar days may be required if the Plan Supervisor determines that, for reasons beyond the Plan Supervisor's control, an extension is necessary. If the Plan Supervisor determines that an extension is required, the Plan Supervisor will notify you within the initial 15-day time period that an extension is necessary.

When the Plan Supervisor requires an extension due to incomplete information, you will have 45 calendar days to provide the required information. If the Plan Supervisor does not receive the required information within the 45-day time period, the claim may be denied. Additionally, the Plan Supervisor will be entitled to an additional 15 days to reach a determination after the additional information is received from you or a Provider. If the Plan Supervisor receives information after the timeframe for providing the information has passed (but within the timeframe for submitting an appeal), the Plan Supervisor will treat the submission of the information as a request for an appeal and will process the claim in accordance with the appeal procedures.

- A. **Urgent Care Claim** – A determination for Urgent Care Claims will be provided to you (in writing or in electronic form) within 72 hours of the Plan Supervisor's receipt of the claim.

An extension of 48 hours may be required if the Plan Supervisor determines that you have failed to provide enough information for the Plan Supervisor to make a determination. If the Plan Supervisor determines that an extension is required, the Plan Supervisor will notify you within 24 hours of the receipt of the Urgent Care Claim. If the Plan Supervisor does not receive the required information from you or your Provider within 48 hours after notifying you, the claim may be denied. If the Plan Supervisor receives information after the timeframe for providing the information has passed (but within the timeframe for submitting an appeal), the Plan Supervisor will treat the submission of the information as a request for an appeal and will process the claim in accordance with the appeal procedures.

The Plan Supervisor will consider a Provider to be your authorized representative without a specific designation by you when the Provider has submitted an Urgent Care Claim on your behalf.

- B. **Concurrent Care Decision** – If the Plan Supervisor makes a decision to stop or reduce Benefits for Concurrent Care that had previously been approved, you will be notified sufficiently in advance of the reduction or termination of Benefits to allow you time to appeal the decision before the Benefits are reduced or terminated.

If you request Concurrent Care Benefits to be extended and the request involves Urgent Care, the request to extend a course of treatment or number of treatments must be made at least 24 hours prior to the expiration of the initially approved period. The Plan Supervisor will make a decision within 24 hours.

2. **Post-service Claim** – A determination for Post-service Claims will be provided to you (in writing or in electronic form) within 30 calendar days of our receipt of the claim if the decision is adverse to you.

An extension of 15 calendar days may be required if the Plan Supervisor determines that, for reasons beyond the Plan Supervisor's control, an extension is necessary. If the Plan Supervisor determines that an extension is required, the Plan Supervisor will notify you within the initial 15-day time period that an extension is necessary.

When an extension is required due to incomplete information, you will have 45 calendar days to provide the required information. If the Plan Supervisor does not receive the required information within the 45-day time period, the claim will be denied. Additionally, the Plan Supervisor will be entitled to an additional 15 days to reach a determination after the additional information is received from you or a Provider. If the Plan Supervisor receives information after the

timeframe for providing the information has passed (but within the timeframe for submitting an appeal), the Plan Supervisor will treat the submission of the information as a request for an appeal and will process the claim in accordance with the appeal procedures.

Denial of Claims

If the Plan Supervisor denies any part or all of a claim, you will receive an Explanation of Benefits (“EOB”) or determination letter explaining the reason(s). A denial will include any Adverse Benefit Determination.

Your notice that you receive will contain:

- i. The specific reason(s) for the Adverse Benefit Determination;
- ii. A reference to the specific Plan provisions on which the determination is based;
- iii. A description of any additional material or information, if any, needed to complete the claim and the reasons such material or information are necessary;
- iv. A description of the claims review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an Adverse Benefit Determination on review;
- v. The disclosure of any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or a statement that such information is available free of charge upon request); and,
- vi. If the reason for the decision is based on an exclusion such as lack of Medical Necessity or Investigational or Experimental Services, an explanation of the scientific or clinical judgment for the determination (or a statement that such information will be provided to you free of charge upon request).

If after reviewing the notice that is provided, you do not understand why the Plan Supervisor denied your claim, you can:

- Read the information in this booklet. It outlines the terms and conditions of your health coverage; or,
- Contact Planned Administrators, Inc. at (800) 768-4375.

If you have failed to follow the Plan requirements in submitting a claim, you will be notified within 5 calendar days.

Appeal Procedures

If you wish to file a formal **appeal**, you must write to:

Planned Administrators, Inc.
Attention: Appeals
P.O. Box 6927
Columbia, SC 29260.

Your letter must state that a formal appeal is being requested and you must include all pertinent information regarding the claim that you want to have considered in the letter. The following guidelines apply for each type of claim (including the appropriate claim with regard to a Concurrent Care decision):

1. Pre-service Claim – You have 180 days to appeal the decision on a Pre-service Claim (including a Concurrent Care decision). The Plan Supervisor will complete the appeal process within 15 calendar days after receiving the appeal. If you still do not agree with the decision, you can submit a second appeal within 90 days after receiving the decision of the first appeal. The Plan Supervisor will complete the second appeal process within 15 calendar days after receiving the second appeal.
2. Urgent Care Claim – You have 180 days to appeal the decision on an Urgent Care Claim. The Plan Supervisor must complete the appeal process within 72 hours after receiving the appeal.
3. Post-service Claim – You have 180 days to appeal the decision on a Post-service Claim. The Plan Supervisor will complete the appeal process within 30 calendar days after receiving the appeal. If you still do not agree with the decision, you can submit a second appeal within 90 days after receiving the decision of the first appeal. The Plan Supervisor must complete the second appeal process within 30 calendar days after receiving the second appeal.

CASE MANAGEMENT

****Case management is provided through a contract between PAI and Blue Cross and Blue Shield of South Carolina****

COMPREHENSIVE CASE MANAGEMENT

In the event of a serious or catastrophic Illness or Injury, the Plan provides for a comprehensive case management program. The comprehensive case management program is a, patient-centered approach to developing a comprehensive plan of cost effective health care. The services provided under the case management program include:

- A. Evaluation and assistance for the Employee, their Physician, and family to help develop a plan of services to meet specific needs;
- B. Assistance with obtaining unusual equipment or supply needs;
- C. Assistance in home care planning and implementation;
- D. Arrangements for needed nursing/caregiver services;
- E. Providing help with assessment of rehabilitation needs and Provider arrangements;
- F. Offering appropriate and effective alternative care/therapy suggestions for Mental and Nervous Treatment and/or treatment for Substance Abuse as determined by medical care review;
- G. Monitoring and assuring treatment programs and interventions for Mental and Nervous Treatment and/or treatment for Substance Abuse; and
- H. Functioning as an effective resource for information on treatment facilities and available care for Mental and Nervous Treatment and/or treatment for Substance Abuse.

The case management program is voluntary and will not provide benefits in excess of those ordinarily available under the Plan.

ALTERNATIVE TREATMENT PLAN UNDER CASE MANAGEMENT

In the course of the case management program, the Plan Administrator shall have the right to alter or waive the normal provisions of this Plan of Benefits when it is reasonable to expect a cost-effective result without a sacrifice to the quality of patient care.

Benefits provided under this section are subject to all other Plan of Benefits provisions. Alternative care 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 Participant or any other Participant. Nothing contained in this Plan of Benefits shall obligate the Plan Administrator to approve an alternative treatment plan.

Maternity Care is a maternity outcome management program which includes monitoring of all pre-natal care to ensure healthy babies, and alternative treatment when medically necessary. Access to ***Maternity Care*** is as follows:

- ***Maternity Care*** should be notified of the expectant mother's delivery date as soon as she finds out she is pregnant, or when a woman is planning to become pregnant.
- In order to identify participants who may be high risk during their pregnancies, all expectant mothers and their physicians will be asked to complete a risk assessment form for ***Maternity Care*** at the beginning of their pregnancies and again during the second trimester.
- The ***Maternity Care*** nurse reviews the assessment form, and determines whether or not the expectant mother is at risk for preterm delivery or pregnancy complications.
- ***Maternity Care*** will contact the expectant mother's physician to assure appropriate prenatal care.
- The expectant mother will be encouraged to visit her physician on a regular basis and keep her scheduled appointments.
- High-risk pregnancies will be monitored by the ***Maternity Care*** nurse who will assist in arranging and monitoring any required special care.

EMPLOYEE SELF-AUDIT PROGRAM

The Group Health Plan will make a cash presentation to any Employee who detects a billing over-charge made by a Provider on medical bills for any covered family member if a billing adjustment is made and the Group Health Plan realizes a savings.

To participate in the self-audit program, after receiving services from a Provider the Employee should simply review the bill for errors. Errors may include: a calculation error, charges for services or supplies the member did not receive, or charges for services or supplies received but not in the quantity indicated.

If the Employee discovers a billing over-charge, the Employee should obtain a corrected bill and take the original and corrected bills and present BOTH to the Plan Supervisor for review and determination. The Plan Supervisor will pay the Employee 20% of the savings up to a maximum of \$500.00. As an example, if an Employee detects an incorrect charge of \$1,200.00 and this is confirmed, the Employee will receive a check for 20% of the savings, or \$240.00 from the Plan.

NOTE: This program does not apply to duplicate billings or to charges in excess of the Usual and Customary charge, regardless of whether the charge is or is not reduced.

MEDICAL SCHEDULE OF BENEFITS

All benefits are subject to the Fee Schedule. Please refer to the Covered Expenses section for a complete listing of Benefits and any additional Conditions/Limitations that may apply. Percentages stated are those paid by the Group Health Plan.

Lifetime Maximum per Participant is \$1,000,000
The Transplant Lifetime Maximum is \$500,000

Benefit Year (B/Y) Deductible:	
Per Participant:	\$0

BENEFIT YEAR:

The B/Y for the Deductible and Out-of-Pocket accumulations is **January 1st through December 31st** of each year.

	PREFERRED PROVIDER (PPO):	NON-PREFERRED PROVIDER (Non-PPO):
Out-of-Pocket Amount (excluding the Deductible)		
Per Participant:	\$2,000	\$3,000
Per Family:	\$4,000	\$6,000

The “**Out-of-Pocket**,” limit is the maximum dollar amount a Participant will pay for covered medical expenses in any one Benefit Year. Upon satisfaction of the Out-of-Pocket Limit, benefits for such Participant will be payable at 100% of the Fee Schedule. **The Out-of-Pocket Limit does not include Benefit Year Deductible, expenses incurred because of Cost Containment penalties, Outpatient Mental/Nervous and Substance Abuse coinsurance, Chiropractic Care expenses, TMJ expenses, expenses for treatment of Flat Feet, expenses incurred due to reduction of the fee schedule payment level, or per-occurrence co-payments.**

Note: The amount applied toward the PPO Out-of-Pocket will also be used in the accumulation towards the satisfaction of the Non-PPO Out-of-Pocket Limit.

INPATIENT HOSPITAL EXPENSES:	PPO:	Non-PPO:
Pre-Authorization required		
Room and Board:	70%	50%
Skilled Nursing Facility:	70%	50%
Physical Rehabilitation Facility: Lifetime maximum of \$100,000	70%	50%
Intensive Care Unit, Cardiac Care Unit, Burn Unit:	70%	50%
Newborn Nursery:	70%	50%
Birth Center: Limited to 24 hours following birth	70%	50%
Physician Expenses:	70%	50%
Pathology/Radiology Charges:	70%	50%
Anesthesia:	70%	50%

MEDICAL SCHEDULE OF BENEFITS—continued

All benefits are subject to the Fee Schedule. Please refer to the Covered Expenses section for a complete listing of Benefits and any additional Conditions/Limitations that may apply.

OUTPATIENT EXPENSES:	PPO:	Non-PPO:
Hospital Surgical Services and Supplies:	70%	50%
Hospital and Physician Charges:	70%	50%
Emergency Room Charges:	70%	50%
Pre-Admission Testing:	70%	50%
Anesthesia:	70%	50%
Cardiac Rehabilitation:	70%	50%
Diagnostic X-ray, Laboratory, Pathology, and Radiology:	70%	50%

MENTAL AND NERVOUS EXPENSES:	PPO:	Non-PPO:
Inpatient Expenses for Hospital and Physician: Limited to 30 days per Benefit Year	70%	50%
Outpatient Expenses for Hospital and Physician: Limited to 20 visits per Benefit Year	70%	50%

SUBSTANCE ABUSE EXPENSES:	PPO:	Non-PPO:
Lifetime maximum of \$25,000		
Inpatient Expenses for Hospital and Physician: Limited to 30 days and/or \$10,000 per Benefit Year	70%	50%
Outpatient Expenses for Hospital and Physician: Limited to 50 visits, \$40 maximum allowed per visit	70%	50%

***NOTE: The day/visit maximums for Mental/Nervous and Substance Abuse are combined.**

PHYSICIAN OFFICE EXPENSES:	PPO:	Non-PPO:
Surgery:	70%	50%
Physician Office Visit: Including Lab, X-ray, Pathology, and Radiology	70%	50%
Injections:	70%	50%

MEDICAL SCHEDULE OF BENEFITS—continued

All benefits are subject to the Fee Schedule. Please refer to the Covered Expenses section for a complete listing of Benefits and any additional Conditions/Limitations that may apply.

OTHER SERVICES:	PPO:	Non-PPO:
Chiropractic Care: Limited to 50 visits—Maximum of \$40 allowed per visit— Benefit Year maximum of \$1,000	50%	50%
Hospice Care: Pre-Authorization required—Lifetime maximum of \$10,000	100%	50%
Home Health Care: Pre-Authorization required—Lifetime maximum of \$10,000	100%	50%
Durable Medical Equipment: Pre-Authorization is required if over \$100	70%	50%
Human Organ/Tissue Transplants: Lifetime maximum of \$500,000—See Human Organ or Tissue Transplant Procedures section for specific limits	70%	50%
Second Surgical Opinion (not mandatory):	70%	50%
Private Duty Nursing: Lifetime maximum of \$10,000	70%	50%
Treatment of Flat Feet: Limited to 50 visits with \$40 allowed per visit and/or \$1,000 per Benefit Year	70%	50%
Temporomandibular Joint Dysfunction—Non-Surgical: Lifetime maximum of \$600	50%	50%
Ambulance:	70%	70%
Routine Colonoscopies:	70%	50%
Physical/Speech/Occupational Therapy:	70%	50%
Radiation Therapy and Chemotherapy:	70%	50%
All Other Covered Services:	70%	50%

WELLNESS SERVICES:	PPO:	Non-PPO:
Limited to \$500 per Participant per B/Y for all Wellness combined.		
Routine Physical Exam: Includes Office Visit, Lab, X-ray and Pathology with office visit on the same day	100%	50%
Routine Gynecological Exam or Prostate Exam: Includes Office Visit, Lab and Pathology	100%	50%
Well-Child Care up to age 6: Includes Routine Office Visits, Lab and Immunizations—Not subject to the Wellness limit	100%	50%
Routine Mammograms:	100%	50%

Pre-Approval
The following items require approval: <ul style="list-style-type: none"> • Home Health Care • Hospice Care • Admissions for physical rehabilitation • Human organ and/or tissue transplants • Durable Medical Equipment when the purchase price or rental cost of the equipment is \$100 or more.

PRESCRIPTION DRUG BENEFITS

Prescription Drug benefits are subject to all of the exclusions contained in the Exclusion section of this Plan of Benefits.

Prescription Drugs are provided through the Caremark Prescription Drug Program. Caremark uses the Medispan defined drug/therapeutic classification for product coverage and exclusion. Outpatient Prescription Drugs will be covered in the following manner:

Participating Pharmacies:

Member pays 30%

NOTE: The Prescription Drug Coinsurance tracks toward the Out-of-Pocket limit. Prescription Drugs are paid at 100% after the Out-of-Pocket is met. Out-of-Pocket limits start over on January 1st.

All Prescription Drugs are covered unless an exclusion applies except for the Prescription Drugs listed on the Schedule of Benefits.

COVERED MEDICAL EXPENSES

This Plan of Benefits provides coverage for a wide range of services and supplies. The charges for these services and supplies are considered covered expenses to the extent that they are: Medically Necessary; prescribed; rendered by a Physician within the scope of his or her license; and provided for care and treatment of a covered Illness or Injury.

Applicable Deductible and/or co-pay amounts and Benefit Percentages payable are listed in the **Medical Schedule of Benefits**. Covered medical expenses are subject to any limitations specified in the **Medical Schedule of Benefits**. Covered medical expenses are subject to all exclusions. Covered medical expenses are only payable based on the Allowed Amount.

Covered medical expenses include charges for the following:

1. Local, professional **ambulance service** for Emergency Services to or from the nearest hospital where Medically Necessary treatment can be given.

Non-emergency ambulance services may be covered to a Skilled Nursing Facility or Hospital if the patient's condition is such that any other method of transportation is inadvisable. All non-emergency ambulance use will be individually considered for Medical Necessity and Prior Authorization should be obtained if possible.

In some cases, emergency transportation by an Air Ambulance may qualify as ambulance service. Air Ambulance service must be Medically Necessary. Medical Necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. All Air Ambulance services will be individually considered for Medical Necessity and Prior Authorization should be obtained if possible.

2. Charges made by an **Ambulatory Surgical Center** or minor emergency medical clinic.
3. Charges for the cost and administration of an **anesthetic**, however, anesthesia rendered by the attending surgeon or their assistant is excluded.
4. Charges for **artificial limbs or breast prosthesis**, to replace body parts when the replacement is necessary because of physiological changes.
5. When an **assistant surgeon** is required to render technical assistance at an operation, the eligible expense for such services shall be limited to 20% of the Usual and Customary Rate (UCR) of the surgical procedure.
6. **Blood transfusions**, including cost of blood, blood plasma, blood plasma expanders, and other blood products not donated or replaced by a blood bank.
7. Phase II **Cardiac rehabilitation** (to improve a patient's tolerance for physical activity or exercise) will be covered under a medically supervised and controlled reconditioning program.
8. Charges for **chiropractic treatment**, subject to the limitations, if any, stated in the Medical Schedule of Benefits.
9. Initial **contact lenses** or one pair of **eye glasses** required following cataract surgery;
10. Charges for **cosmetic surgery**, only for the following situations:
 - A. When the malappearance or deformity is due to a congenital anomaly; or
 - B. When due solely to surgical removal of all or part of the breast tissue because of an Injury or Illness to the breast; or
 - C. When required for the medical care and treatment of a cleft lip and palate.

Coverage for the proposed cosmetic surgery or treatment must be pre-authorized by the Medical Review Department prior to the date of that surgery or treatment.

11. Charge for **dental services** rendered by a Physician for treatment of an Accidental Injury to natural teeth if all treatment is rendered within twelve (12) months of the Accidental Injury.

12. Charges for Prescription **Drugs** requiring a written prescription of a licensed Physician; such drugs must be necessary for the treatment of an Illness or Injury.
13. Charges for **Durable Medical Equipment** (such as, renal dialysis machines, resuscitators or Hospital-type beds), required for temporary therapeutic use in the Participant's home by an individual patient for a specific condition when such equipment is not ordinarily used without the direction of a Physician. If such equipment is not available for rent, the monthly payments toward the purchase of the equipment may be approved by the Plan Supervisor. Benefits will be reduced to standard equipment allowances when deluxe equipment is used. The rental or purchase benefits cannot exceed the purchase price of the equipment. **Pre-Authorization required for expenses over \$100.**
14. Charges for **electrocardiograms**, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.
15. Treatment or diagnostic services by a Physician for:
 - A. Weak, strained or **Flat Feet** or instability or imbalance of the feet;
 - B. Any tarsalgia, metatarsalgia, or bunion other than operations involving the exposure of bones, tendons or ligaments; or
 - C. Toe nails (other than the removal of nail matrix or root; or the removal by cutting or any other method of superficial lesions of the feet including corns, callouses and hyperkeratosis, up to the maximums in the Medical Schedule of Benefits.
16. **Home Health Care**, subject to the limitations, if any, stated in the Medical Schedule of Benefits, when rendered to a homebound Participant in the Participant's place of residence. Home Health Care must be rendered by or through a community Home Health agency, must be provided on a part-time visiting basis and must be provided according to a Physician-prescribed course of treatment. Pre-Service Authorization must be obtained from the Medical Review Department before a Participant is eligible for Home Health Care benefits. Benefits for Home Health Care includes those services and supplies that are usually provided by a Hospital or Skilled Nursing Facility to an inpatient by a registered or licensed practical nurse.
17. Charges relating to **Hospice Care**, provided that the participant has a life expectancy of six (6) months or less and subject to the maximums, if any, stated in the Medical Schedule of Benefits. Pre-Service Authorization by the Medical Review Department must be obtained prior to beginning Hospice Care. This coverage includes bereavement counseling. Bereavement counseling is a supportive service provided by the Hospice team to participants in the decedent's immediate family after the death of such terminally ill person. Such visits are to assist the participants in adjusting to the death, and are covered as follows: if on the date immediately before his/her death, the terminally ill person was in a Hospice Care Program and a Participant under the Plan of Benefits; and charges for such services are incurred by the immediate family within twelve (12) months of the terminally ill person's death.
18. **Hospital Charges** for:
 - A. Daily room and board charges in a Hospital, not to exceed the daily semi-private room rate (charges when a Hospital private room has been used will be reimbursed at the average semi-private room rate in the facility). Hospitals with all private rooms will be allowed at the prevailing private room rate;
 - B. The day on which a Participant leaves a Hospital or Skilled Nursing Facility, with or without permission, is treated as the discharge day and will not be counted as an inpatient care day, unless he returns to the Hospital by midnight of the same day. The day the Participant returns to the Hospital or Skilled Nursing Facility is treated as the Admission day and is counted as an inpatient care day. The days during which the Participant is not physically present for inpatient care are not counted as Inpatient days;
 - C. Confinement in an Intensive Care Unit, Cardiac Care Unit or Burn Unit;
 - D. Miscellaneous hospital services and supplies during Hospital confinement if such charges should not have been included in the underlying hospital charge (as determined by the Plan);
 - E. Inpatient charges for well Newborn Care for nursery room and board and for professional service. Eligible expenses will be subject to the fee schedule rates for pediatric services and circumcision; and
 - F. Outpatient Hospital services and supplies and emergency room treatment.

19. Routine **mammograms** subject to the limitations as stated in the Medical Schedule of Benefits. Non-Routine Mammograms are covered when Medically Necessary.
20. Charges for **maternity care**. Dependent children are not eligible for benefits under this provision.
21. Charges incurred under the “**Maternity Care**” (maternity outcome management) program including monitoring of all pre-natal care to ensure healthy babies, and alternative treatment when medically necessary.
22. Any expenses incurred in obtaining **medical records** in order to substantiate Medical Necessity.
23. **Medical supplies**, including but not limited to the following:
 - A. Syringes, and related supplies for conditions such as diabetes;
 - B. Dressing for conditions such as cancer or burns;
 - C. Catheters;
 - D. Colostomy bags and related supplies;
 - E. Test tapes;
 - F. Necessary supplies for renal dialysis equipment or machines; and
 - G. Surgical trays.
24. Charges for dressings, sutures, casts, splints, trusses, crutches, pacemakers, braces (not dental braces) or other **medical supplies** determined by the Plan to be appropriate for treatment of an Illness or Injury.
25. Charges for **Mental and Nervous Treatment** if rendered by a licensed medical Physician (M.D.), licensed psychologist (Ph.D); or clinical psychologist. Benefits are subject to the limitations stated in the Medical Schedule of Benefits. Expenses for Psychological Testing are also covered.
26. Charges for **Newborn Care**. The Plan of Benefits will comply with the terms of the Newborns’ and Mothers’ Health Protection Act of 1996. The Plan of Benefits will not 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 to less than ninety-six (96) hours following a cesarean section. However, the mother’s or Newborn’s attending Provider, after counseling with the mother, may discharge the mother or her Newborn earlier than the forty-eight (48) hours (or ninety-six (96) hours if applicable).
27. Charges for the treatment and services rendered by a **occupational therapist** in a home setting, at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing outpatient facility, up to a maximum shown, if any, as stated in the Medical Schedule of Benefits.
28. Charges for the following **oral surgical procedures**:
 - A. Excision of wholly or partly un-erupted impacted teeth;
 - B. Open or closed reduction of a fracture or dislocation of the jaw; and
 - C. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when a lab exam is required; excision of benign bony growths of the jaw and hard palate; external incision and drainage of cellulitis and incision of sensory sinuses, salivary glands or ducts.
29. Charges for **oxygen** and other gases and their administration.
30. Charges incurred for Admission in a **physical rehabilitation facility or Skilled Nursing Facility**, subject to the limitations, if any, stated in the Medical Schedule of Benefits for participation in a multidisciplinary team-structured rehabilitation program following severe neurologic or physical impairment. The Participant must be under the continuous care of a Physician and the attending Physician must certify that the individual requires nursing care 24 hours a day. Nursing care must be rendered by a registered nurse or a licensed vocational or practical nurse. The confinement cannot be primarily for domiciliary, custodial, personal type care, care due to senility, alcoholism, drug abuse, blindness, deafness, mental deficiency, tuberculosis, or Mental Disorders. This Benefit shall not include charges for vocational therapy or Custodial Care.

31. Charges for the treatment or services rendered by a **physical therapist** in a home setting, a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing duly licensed outpatient therapy facility, subject to the limitations, if any, stated in the Medical Schedule of Benefits.
32. Charges for the services of a **Physician** for medical care and/ or surgical treatments including office, home visits, Hospital inpatient care, Hospital outpatient visits/exams, clinic care, and surgical opinion consultations, subject to the following:

In-Hospital medical service consists of a Physician's visit or visits to a Participant who is a registered bed-patient in a Hospital or Skilled Nursing Facility for treatment of a condition other than that for which surgical service or Obstetrical service is required, as follows:

 - A. In-Hospital medical benefits will be provided limited to one visit per specialty per day;
 - B. In-Hospital medical benefits in a Skilled Nursing Facility;
 - C. When two or more Physicians, within the same study, render in-Hospital medical services at the same time, payment for such service will be made only to one Physician; and
 - D. Concurrent medical/surgical care benefits for in-Hospital medical service in addition to benefits for surgical service will be provided only:
 - a. When the condition for which in-Hospital medical service requires medical care not related to Surgical or obstetrical service and does not constitute a part of the usual, necessary and related pre-operative and post-operative care but requires supplemental skills not possessed by the attending surgeon or his assistant; or
 - b. When a Physician other than a surgeon admits a Participant to the Hospital for medical treatment and it later develops that surgery becomes necessary such benefits cease on the date of surgery for the admitting Physician and become payable under the surgeon only; or
 - c. When the surgical procedure performed is designated by the Plan Supervisor as a "warranted diagnostic procedure" or as a "minor surgical procedure".
33. **Pre-Admission testing** for a scheduled Admission when performed on an outpatient basis prior to such Admission. The tests must be in connection with the scheduled Admission and are subject to the following:
 - A. The tests must be made within seven (7) days prior to Admission; and
 - B. The tests must be ordered by the same Physician who ordered the Admission and must be Medically Necessary for the Illness or Injury for which the Participant is subsequently admitted to the Hospital.
34. Charges for **radiation therapy** or treatment, and **chemotherapy**.
35. Expenses for a **Second Opinion** (Not Mandatory). The Second Opinion must be rendered by a board certified surgeon who is not professionally or financially associated with the Physician or the surgeon who rendered the first surgical opinion. The surgeon who gives the second surgical opinion may not perform the surgery. If the Second Opinion is different from the first, a third opinion will also be payable provided the opinion is obtained before the procedure is performed. The conditions that apply to a Second Opinion also apply to any third surgical opinion.
36. Fees of a licensed **speech therapist** for restorative speech therapy for speech loss or impairment due to:
 - A. Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenulectomy); or
 - B. An Injury; or
 - C. An Illness that is other than a learning or Mental Disorder.
37. Charges for **Substance Abuse** treatment will be payable if rendered by a licensed medical Physician (M.D.), licensed psychologist (Ph.D.), clinical psychologist, licensed social worker or licensed counselor. Services or charges for Detoxification are also covered. The amount of days needed for treatment is determined through psychiatric care pre-authorization, not to exceed ten (10) days.
38. Subject to the determination of the Medical Review Department, charges for **surgical procedures**, subject to the following:

- A. If two or more operations or procedures are performed at the same surgical approach, the total amount covered for the operations or procedures will be payable for the major procedure only, or benefits will be payable according to the recommendations of the Medical Review Department;
 - B. If two or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be paid according to the Allowed Amount for the operation or procedure bearing the highest allowance, plus one half of the Allowed Amount for all other operations or procedures performed;
 - C. If an operation consists of the excision of multiple skin lesions, the total amount covered will be paid according to the Allowed Amount for the procedure bearing the highest allowance, 50 percent (50%) for procedures bearing the second and third highest allowance, 25 percent (25%) for procedures bearing the fourth through the eighth highest allowance, and 10 percent (10%) for all other procedures;
 - D. If an operation or procedure is performed in two or more steps or stages, coverage for the entire operation or procedure will be limited to the allowance for such operation or procedure;
 - E. If two or more Physicians perform operations or procedures in conjunction with one another, other than as an assistant at surgery or anesthesiologist, the allowance, subject to the above paragraphs, will be pro-rated between them by the Plan Supervisor when so required by the Physician in charge of the case; and
 - F. Certain surgical procedures, which are normally exploratory in nature, are designated as “independent procedures” by the Plan Supervisor, and the Allowed Amount is covered when such a procedure is performed as a separate and single entity. However, when an independent procedure is performed as an integral part of another surgical service, the total amount covered will be paid according to the Fee Schedule for the major procedure only.
39. Non-surgical procedures, x-rays, office visits and appliances related to dysfunctional conditions of the muscles of mastication, malpositions, or deformities of the jaw bone(s), orthognathic deformities, or **Temporomandibular Joint Disorders (TMJ)**, up to the maximum in the Medical Schedule of Benefits.
40. Charges for hyperalimentation or **total parenteral nutrition (TPN)** for person recovering from or preparing for surgery.
41. Charges for services for **voluntary sterilization** for Participants.
42. Charges for **wellness services**.
43. Charges for **x-rays**, microscopic tests, and **laboratory tests**.

HUMAN ORGAN OR TISSUE TRANSPLANT BENEFITS

When pre-approved by the Corporation [and performed by a Provider the Corporation designates], Benefits are payable for all expenses for medical and surgical services and supplies incurred while covered under this Plan of Benefits for Human Organ/Tissue transplants as indicated in the following paragraphs. The Benefits are subject to the Deductible amount, Coinsurance percentage and/or money maximum specified in the Medical Schedule of Benefits.

1. Benefits are available for human organ, tissue and bone marrow transplantation, subject to determination made on an individual, case by case, basis in order to establish medical necessity. Pre-Authorization must be obtained in writing from the Medical Review Department.
2. Benefits will be provided only when the Hospital and Physician customarily charge a transplant recipient for such care and services.
3. When only the transplant recipient is a Covered Participant, the Benefits of the Plan will be provided for the recipient. Benefits will also be provided for the donor under this Plan of Benefits to the extent that such Benefits are not provided under any other form of coverage. In no such case under the Plan of Benefits will any payment of a "personal service" fee be made to any donor. Only the necessary Hospital and Physicians' medical care and services expenses with respect to the donation will be considered for Benefits.
4. When only the donor is a Participant, the donor will receive benefits for care and services necessary to the extent that such benefits are not provided under any recipient who is not a Participant under this Plan of Benefits. The recipient will not be eligible for benefits when only the donor is a Participant.
5. When the recipient and the donor are both Participants, benefits will be provided for both in accordance with the respective Group Health Plan covered expenses.

Health care benefits for transplants include covered expenses such as patient work-up, travel (as specified below), pre-transplant care, the transplant, post-transplant care, and immunosuppressive drugs (while inpatient). All Benefits provided during a Transplant Benefit Period will apply toward the Transplant Lifetime Maximums listed below, except for anti-rejection drugs. For transplants not listed below, the Corporation will determine the Transplant Lifetime Maximum on an individual basis.

Liver	\$300,000
Lung (Single)	\$130,000
Lung (Double)	\$250,000
Heart	\$120,000
Heart & Lung (Single)	\$200,000
Heart & Lung (Double)	\$350,000
Pancreas	\$80,000
Pancreas and Kidney	\$120,000
Kidney (Single)	\$75,000
Kidney (Double)	\$150,000
Bone Marrow	\$250,000
Cornea	\$25,000
Travel Expense Services	\$5,000*

Note: Amounts paid for Prescription Drugs will not apply to the transplant maximum.

There is a Lifetime maximum on transplants of \$500,000.

***Transplant Travel Expense Services**

Benefits for transportation, lodging and food are available to you only if you or your covered Dependent is the recipient of a pre-approved organ/tissue transplant from a pre-approved, in-network transplant facility.

Health care benefits for transplant travel services are subject to the Transplant Travel Benefit Maximum of \$5,000 and the Lifetime Transplant Maximum Benefits, include coverage for travel expenses incurred by you or your covered Dependent as well as for charges resulting from transportation, lodging (up to \$150 a day) and food (up to \$75 a day) associated with a pre-approved organ/tissue transplant.

These benefits are not subject to any individual or family deductible shown in The Medical Schedule of Benefits referenced within this document. These benefits are only available if you or your Dependent is the recipient of an organ/tissue transplant. No benefits are available if you or your Dependent is a donor.

The term recipient is defined to include you or your covered dependent pre-approved transplant related services during any of the following:

- a) evaluation;
- b) candidacy
- c) transplant event; or
- d) post-transplant care.

Travel expenses for the person receiving the transplant will include charges for:

1. transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
2. lodging while at, or traveling to and from the transplant site; and
3. food while at, or traveling to and from the transplant site.

The charges associated with the items (1), (2) and (3) above will also be considered covered travel expenses for one companion to accompany you. The term companion includes a spouse, family member, legal guardian of you or your Dependent, or any person not related to you, but actively involved as your caregiver.

By way of example, but not of limitation, travel expenses will not include any charges for:

- (a) transplant travel benefit costs incurred due to travel within 60 miles of your home;
- (b) laundry bills;
- (c) telephone bills;
- (d) alcohol or tobacco products; and
- (e) transportation charges which exceed coach class rates.

EXCLUSIONS AND LIMITATIONS

The exclusions and limitations in this section apply to all expenses incurred by all Participants. The following are **excluded from coverage** under this Plan of Benefits:

- 1 Any service or supply that is not **Medically Necessary**.
- 2 Charges incurred as a **result of declared or undeclared war or any act of war** or caused during service in the armed forces of any country.
- 3 **Professional services** billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- 4 **Travel expense**, whether or not recommended by a Physician.
- 5 Any medical **social services, vision, recreational or Milieu Therapy, education testing or training**, except as part of pre-authorized Home Health Care or Hospice Care Program.
- 6 **Nutritional counseling or vitamins, food supplements and other dietary supplies** even if the supplements are ordered or prescribed by a Physician. Exceptions to this exclusion are noted under the Medical Schedule of Benefits and the Prescription Drug Benefits section.
- 7 Services, supplies or charges for **pre-marital and pre-employment physical examinations**.
- 8 Any service or supply for which a Participant is entitled to receive payment or Benefits (whether such payment or Benefits have been applied for or paid) under any law (now existing or that may be amended) of the United States or any state or political subdivision thereof, except for Medicaid. These include, but may not be limited to, Benefits provided by or payable under **worker's compensation laws**, the Veteran's Administration for care rendered for service-related disability, or any state or federal Hospital services for which the Participant is not legally obligated to pay. This exclusion applies if the Participant receives such Benefits or payments in whole or in part, and is applied to any settlement or other agreement regardless of how it is characterized and even if payment for medical expenses is specifically excluded.
- 9 Services to the extent that the Participant is entitled to payment or Benefits under any **State or Federal** program that provides health care benefits, including Medicare, but only to the extent that Benefits are paid or are payable under such programs.
- 10 Charges incurred for which the Participant is not in the absence of this coverage **legally obligated** to pay or for which a charge would not ordinarily be made in the absence of this coverage.
- 11 Charges resulting from or occurring: (1) during the **commission of a crime** by the Participant; or (2) while engaged in an illegal act, illegal occupation, felonious act or aggravated assault, except to the extent that the charges are related to a medical condition or an act of domestic violence.
- 12 Charges incurred for services or supplies which constitute **personal comfort or beautification items**, such as television or telephone use.
- 13 All **Cosmetic Procedures** in which the purpose is improvement of appearance or correction of deformity without restoration of bodily function. Some procedures may, under certain circumstances, be considered to be restorative in nature, when they are performed to correct a loss of function, pain, a malappearance or deformity that was caused by physical trauma, surgery or congenital anomaly. In order for benefits to be available for such restorative surgery, coverage for the proposed surgery or treatment must have Pre-Authorization by the Medical Review Department prior to the date of that surgery or treatment. Coverage for cosmetic surgery is available as outlined in the Covered Expenses section of this Plan of Benefits.
- 14 Charges for **Custodial Care**, including sitters and companions.
- 15 Charges which are not necessary for treatment of an active Illness or Injury or are in excess of the **Allowed Amount**, or are not recommended and approved by a Physician.

- 16 Charges for **services, supplies, or treatment** not commonly and customarily recognized throughout the Physician's profession or by the American Medical Association as generally accepted and Medically Necessary for the Participant's diagnosis and/or treatment of the Participant's Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.
- 17 Charges for services rendered by a Physician, nurse or licensed therapist who is a **Close Relative** of the Participant, or resides in the same household as the Participant.
- 18 Charges **incurred outside the United States** if the Participant traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies.
- 19 Charges for Inpatient confinement, primarily for x-rays, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent, custodial or rest care, or any medical examination or test **not connected with an active Illness or Injury**, unless otherwise provided under any preventable care covered under this Plan of Benefits.
- 20 Charges incurred in connection with **routine vision care, eye refractions, the purchase or fitting of eyeglasses, contact lenses, hearing aids, or such similar aid devices**. This exclusion shall not apply to aphakic patients and soft lenses, or sclera shells intended for use as corneal bandages, or the initial purchase of eyeglasses or contact lenses following cataract surgery. This exclusion includes any surgical procedure for the correction of a **visual refractive problem**, including radial keratotomy.
- 21 Charges incurred for treatment on or to the **teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes**. Benefits will be payable for charges incurred for treatment required because of Accidental Injury to natural teeth, or for any oral surgical procedure listed under this Plan of Benefit's Covered Medical Expenses.
- 22 Treatment of **infertility** (including the reversal of voluntary sterilization).
- 23 **Experimental or Investigational** services, including surgery, medical procedures, devices or drugs. The Group Health Plan reserves the right to approve, upon medical review, non-labeled use of chemotherapy agents that have been approved by the Federal Drug Administration (FDA) for cancer.
- 24 Charges for **custom molded inserts and/or orthotics**.
- 25 Charges for **maintenance care**. Unless specifically mentioned otherwise, the Plan of Benefits does not provide benefits for services and supplies intended primarily to maintain a level of physical or mental function.
- 26 Any service or supply rendered to a Participant for the treatment of **obesity** or for the purpose of weight reduction. This includes all procedures designed to restrict the Participant's ability to assimilate food. For example, gastric by-pass, the insertion of gastric bubbles, the wiring shut of the mouth, and any other procedure the purpose of which is to restrict the ability of the Participant to take in food, digest food or assimilate nutrients. Also excluded from coverage are those procedures concerning the correction of complications that arise from such excluded diversionary or restrictive procedures; procedures whose purpose is the reversal of these restrictive or diversionary procedures and such reconstructive procedures as may be necessitated by the weight loss produced by these non-covered restrictive or diversionary procedures.
- 27 Marriage, family, child, or pastoral **counseling** for the treatment of pre-marital, marital, family or child relationship dysfunctions.
- 28 Any service or treatment for complications resulting from any **non-covered procedures**.
- 29 Any service or supply rendered to a Participant for the diagnosis or treatment of **sexual dysfunction** (including impotence) except when Medically Necessary due to an organic disease. This includes, but is not limited to, drugs, laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition.
- 30 Any charges for **elective abortions**, except for abortion performed in accordance with federal Medicaid guidelines.
- 31 Charges for a **Dependent child's pregnancy**, including abortions, except for pregnancy as the result of a criminal act.

- 32 Charges not included as part of a Hospital bill for autologous which involves collection and storage of a patient's own blood prior to elective surgery.
- 33 Charges incurred for **take home drugs** upon discharge from the Hospital.
- 34 **Sitters or companions.**
- 35 **Spare items** of the nature of braces of the leg, arm, back and neck, artificial arms, legs or eyes, lenses for the eye or hearing aids, unless needed due to physiological changes.
- 36 Care and treatment of **hair loss.**
- 37 **Exercise programs** for treatment of any condition.
- 38 Air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, wigs, except for post-mastectomy surgery, non-Prescription Drugs, and medicines, first aid supplies and non-Hospital adjustable beds.
- 39 **Acupuncture or hypnosis**, except when performed by a Physician in lieu of anesthesia.
- 40 Care and treatment for **sleep apnea**, unless Medically Necessary.
- 41 **Prescription drugs used for or related to birth control, weight control, obesity, cosmetic purposes, hair growth, fertility and smoking cessation** unless noted as covered under the Medical Schedule of Benefits or the Prescription Drug Benefits.
- 42 Charges which exceed any **benefit limitations** stated in the Medical Schedule of Benefits of this Plan Document.
- 43 Services and supplies received as the result of any intentionally **self-inflicted injury** that does not result from a medical condition or domestic violence.
- 44 **Physician's charges** for medicine, drugs, appliances, supplies, blood and blood derivatives.
- 45 Any inpatient hospital charges incurred on a **Friday, Saturday or Sunday** if admission is made on one of these days unless surgery is performed within 24 hours of the admission or the admission is necessitated by an emergency.
- 46 Procedures to diagnose or **treat the condition of a fetus** prior to birth, except for:
 - A. Amniocentesis and/or chromosomal analysis;
 - B. Fetal monitoring; or
 - C. Pregnancy related ultrasounds.
- 47 **Prescription Drug Exclusions.** The following are not covered under this Plan of Benefits:
 - A. Any over-the-counter medication, unless specified otherwise.
 - B. Prescription Drugs not approved by the Food and Drug Administration;
 - C. Prescription Drugs for non-covered therapies, services, or conditions;
 - D. Prescription Drug refills in excess of the number specified on the Physician's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;
 - E. Unless different time frames are specifically listed on the Schedule of Benefits, more than a thirty-one (31) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy) or unless the quantity is limited by a QVT program;
 - F. Any type of service or handling fee (with the exception of the dispensing fee charged by the pharmacist for filling a prescription) for Prescription Drugs, including fees for the administration or injection of a Prescription Drug;

- G. Dosages that exceed the recommended daily dosage of any Prescription Drug as described in the current Physician's Desk Reference or as recommended under the guidelines of the Pharmacy Benefit Manager, whichever is lower;
 - H. Prescription Drugs administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not a Pharmacy licensed to dispense Prescription Drugs in the state where it is operated;
 - I. Prescription Drugs for which there is an over-the-counter equivalent and over-the-counter supplies or supplements;
 - J. Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the Food and Drug Administration for treatment of that condition (except for Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one standard, universally accepted reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journals);
 - K. Prescription Drugs that are not consistent with the diagnosis and treatment of a Participant's illness, injury or condition, or are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care;
 - L. Prescription Drugs or services that require Pre-Authorization by the Corporation and Pre-Authorization is not obtained;
 - M. Prescription Drugs for injury or disease that are paid by worker's compensation benefits (if a worker's compensation claim is settled, it will be considered paid by worker's compensation benefits); and
 - N. Prescription Drugs that are not Medically Necessary.
- 48 **Home Health Care Exclusions.** The following are excluded from coverage under the Home Health Care benefit:
- A. Services and supplies not included in the Medical Schedule of Benefits, but not limited to, general housekeeping services and services for Custodial Care; and
 - B. Services of a person who ordinarily resides in the home of the participant, or is a Close Relative of the participant; and
 - C. Transportation services.

ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan of Benefits for employees and their Dependents shall be in accordance with the Eligibility, Participant Effective Date and Termination provisions as stated in this Plan of Benefits document.

ELIGIBILITY

To be eligible for coverage under the Plan of Benefits an employee must:

- A. Be employed by the Employer on a regular, full time basis for at least thirty (30) full-time hours per week; and**
- B. have been Actively at Work for a continuous period of at least thirty (30) days unless the cause of the break in this period has been the result of a Health Status Related Factor, except absence related to Substance Abuse or chemical dependency.**

An eligible employee may initially enroll in the Plan of Benefits on the first day of the month following thirty (30) days of Full-time Employment.

EARLY RETIREES

Full time faculty members, administrative officers or directors whose accumulative age and years of service equal seventy five (75) and will be sixty two (62) in the year of early retirement shall be eligible for Early Retiree coverage (benefits are the same as those for active full-time employees). Benefits will be paid through the last day of the month in which the retiree reaches the age of sixty-five (65). However, the covered spouses of any such early retirees may continue coverage until the spouse is eligible for Medicare. This coverage is available for employees who are granted retirement prior to age 65 and who meet the above criteria. Employees who retire at age sixty-five (65) and older are not eligible for this coverage.

Part-time or temporary employees are not eligible for coverage under this Plan of Benefits.

DEPENDENT ELIGIBILITY

An Employee's Dependent(s) will become eligible for Dependent coverage on the latest of the following:

- A. The date the Employee becomes eligible for Employee coverage; or
- B. The date on which the Employee first acquires a Dependent; or
- C. The date the Employee first comes within the classification (if any) and is eligible for Dependent coverage as stated on the Schedule of Benefits.

If both the husband and wife are employed by the Employer, and both are eligible for Dependent coverage, either the husband or wife, but not both, may elect Dependent coverage for their eligible Dependents. No one can be covered under this Plan of Benefits as both an Employee and a Dependent. A person's eligibility for or receipt of Medicaid assistance will not be considered in enrolling that person for coverage or in making benefit payments.

A Dependent will be eligible for coverage in accordance with the following:

- A. To be covered under this Plan of Benefits, a Dependant Child must be properly enrolled as a Dependent of the Participant within thirty-one (31) days of the child's date of birth. If enrolled within 31 days of birth, Newborn children of a covered employee will be covered from the moment of birth, subject to the covered medical expenses and exclusions of this Plan of Benefits. This provision shall not apply nor in any way affect the normal maternity provisions applicable to the mother.
- B. A spouse is an eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a Dependent of the Employee within thirty-one (31) days of the date of marriage.

- C. If a Dependent child is acquired other than at the time of his birth, due to legal adoption or guardianship, that Dependent is an eligible Dependent from the date of such occurrence, provided that this new Dependent is properly enrolled within thirty-one (31) days of legal adoption, placement for adoption, or guardianship.
- D. An unmarried child who reaches the age of nineteen (19) will remain eligible for coverage under this Plan if he/she is incapable of self-sustaining employment and is dependent upon the employee for support 51% or more of the time due to mental or physical illness or handicap. Proof of incapacitation must be provided within thirty-one (31) days of the child's nineteenth (19) birthday and thereafter as requested by the Plan Supervisor but not more than once every two years. The Dependent must have been covered under this Plan of Benefits before attaining the limiting age in order to be eligible for continued coverage.
- E. An unmarried child age nineteen (19) or older but under the age of twenty-four (24), if such unmarried child is a high school student or a Full-time Student at an accredited university, college or trade school, and is chiefly Dependent upon the Employee for support. Plan Administrator may (from time to time) request information documenting (as determined by the Plan Administrator) such Dependent's status.

EFFECTIVE DATE OF COVERAGE

PARTICIPANT EFFECTIVE DATE

Employee coverage under this Plan of Benefits is effective with respect to an eligible employee on the date this Plan of Benefit's enrollment requirements have been met, provided the Employee is Actively at Work on that date and the Employee has applied for coverage on or before such date. If the Employee applies for coverage within thirty-one (31) days of becoming eligible, the Employee's coverage shall become effective on the date that application is made. If an Employee is not in active service on the date coverage would otherwise become effective, coverage shall become effective on the date he or she returns to active service.

Late Enrollee Provision

An Employee who enrolls for coverage under this Plan of Benefits other than during the first period in which the Employee is eligible to enroll (if such initial enrollment period lasts at least thirty (30) days) or during a Special Enrollment period, is a Late Enrollee and is subject to the requirements of this provision. Late Enrollees are subject to an eighteen (18) month Pre-existing Condition Exclusion Period.

Special Enrollment Period

A Special Enrollment Period is a period during which an Employee or Dependent who is not enrolled for coverage under this Plan of Benefits may enroll for coverage under certain permitted circumstances. A Special Enrollment Period applies (and the Employee or Dependent may enroll in this Plan of Benefits) if:

- A. The Employee or Dependent was covered under another Group Health Plan or had Creditable Coverage at the time coverage was previously offered to the Employee or Dependent; and
- B. The Employee provided a written statement at the time of eligibility that other Health Insurance Coverage was the reason for declining enrollment, provided the Employer required such a statement and notified the Employee of this requirement and the consequences for non-compliance; and
- C. The Employee's or Dependent's coverage described above:
 1. was under a COBRA continuation provision and the coverage was exhausted, or
 2. was not under a COBRA continuation provision and the coverage was terminated as a result of loss of eligibility, or reduction in the number of hours of employment, or the employer's contributions to such coverage were terminated; or
 3. was either 1) one of multiple plans offered by an employer and the Employee elected a different plan during an open enrollment period or 2) when an employer terminates all similarly situated individuals; or
 4. was under an HMO that no longer serves the area in which the Employee lives, works or resides; or
 5. was under a Plan where the member incurs a claim that would meet or exceed a lifetime limit on all benefits. The Special Enrollment period is continued until at least thirty (30) days after a claim is denied due to the operation of the lifetime limit on all benefits, and
- D. The Employee or Dependent requests such enrollment not more than thirty-one (31) days after date of exhaustion of coverage or termination of coverage or Employer contribution.

Medicaid or State Children's Health Insurance Program Coverage

- A. The Employee or Dependent was covered under a Medicaid or State Children's Health Insurance Program plan and coverage was terminated due to loss of eligibility; or
- B. The Employee or Dependent becomes eligible for assistance under a Medicaid or State Children's Health Insurance Program plan; and
- C. The Employee or Dependent requests such enrollment not more than sixty (60) days after either:
 - i. date of termination of Medicaid or State Children's Health Insurance Program coverage or
 - ii. determination that the Employee or Dependent is eligible for such assistance.

Under the Special Enrollment provisions of this Plan of Benefits, if an Employee is enrolled in or is eligible under a Plan of Benefits and he or she marries, has a child or adopts a child (or child placed for adoption), the new Dependent(s) may obtain coverage under this Plan of Benefits. The Employee and Employee's spouse may also enroll

at this time as long as they meet the Plan of Benefit's eligibility requirements. Coverage must be added or terminated within thirty-one (31) days of such event. Coverage will be effective on the date of the event. If coverage is added more than thirty-one (31) days from the life event/family status change or special enrollment event, such enrollee will be considered a Late Enrollee and subject to all Late Enrollee provisions.

A twelve (12) month Pre-existing Condition Exclusion Period will apply to Special Enrollees. However, the Pre-existing Condition Exclusion Period can be reduced by the Special Enrollee's Creditable Coverage (as submitted by the Employee or Dependent).

You may request a Certificate of Creditable Coverage at any time by contacting the PAI Customer Service Department at 1(800) 768-4375.

DEPENDENT EFFECTIVE DATE

Coverage for Dependents will commence as follows:

- A. If (during the Employee's initial eligibility period) the Employee submits an enrollment form requesting Dependent coverage, the Dependents will be covered on the same date that Employee coverage becomes effective.
- B. If a Covered Employee requests coverage for his Dependent(s) within thirty-one (31) days from the date the Employee acquires the Dependent(s), but after the date on which the Employee's Coverage became effective, coverage for the Dependent will become effective on the first day of the month following enrollment or the first day following the date of hire.
- C. If the Covered Employee requests Dependent coverage more than thirty-one (31) days from his Effective Date of coverage, such Dependent will be a Late Enrollee and subject to all Late Enrollee provisions.
- D. If a Dependent Child is properly enrolled as a Dependent within thirty-one (31) days of the Child's date of birth, the Child will be covered from the moment of birth, subject to the covered medical expenses and exclusions of this Plan of Benefits. This provision shall not apply nor in any way affect the normal maternity provisions applicable to the mother.
- E. For adopted and foster children of the Employee, coverage shall commence as follows:
 1. If the Employee provides the Plan Administrator with a decree of adoption thirty-one (31) days after the date of the child's birth, coverage shall be retroactive to the moment of the child's birth.
 2. If the Employee institutes adoption proceedings within thirty-one (31) days after the child's birth and the Employee has obtained temporary custody of the child, coverage shall be retroactive to the moment of the child's birth.
 3. For adopted children other than Newborns, coverage shall begin upon Employee's obtaining temporary custody. Such coverage may continue for up to a year; provided that if an order of adoption is entered, the coverage shall continue so long as the child meets the definition of a Dependent. Coverage may be extended upon order of a court.

In all cases, any required premium must be paid before coverage will become effective.

For a spouse taking Dependent coverage based on the birth, placement, or adoption of a child, coverage shall commence on the same date for the spouse as would apply to the child.

Each Employee who wants coverage for his Dependent(s) hereunder must submit a request for coverage (on a form approved by the Plan Administrator).

PRE-EXISTING CONDITION PROVISIONS

PRE-EXISTING CONDITION EXCLUSION PERIOD

Treatment for a Pre-existing Condition will not be covered for twelve (12) months (eighteen (18) months for Late Enrollees) following a Participant's Enrollment Date. Once this exclusion period has been satisfied, normal benefits will be payable.

The Pre-existing Condition Exclusion Period **does not apply** to pregnancy (regardless of whether the woman had previous coverage) or to coverage for a newborn Dependent child or adopted child under age eighteen (18) provided that the requirements related to enrollment for a newborn Dependent child or adopted child are met.

The Plan's Pre-existing Condition Exclusion Period may be reduced by the amount of any immediately preceding continuous Creditable Coverage as long as there is no break in coverage of sixty-three (63) consecutive days or more. Individuals have a right to demonstrate prior health coverage to reduce the Plan's Pre-Existing Condition Exclusion Period by providing a Certificate of Creditable Coverage or other proof of coverage.

TERMINATION OF COVERAGE

A. TERMINATION OF COVERED EMPLOYEE'S COVERAGE

Except as provided in the Group Health Plan's continuation provision, coverage will terminate on the earliest of the following occurrences:

1. The date employment is terminated;
2. If the covered Employee fails to remit required contributions for his coverage when due, his coverage will terminate at the end of the period for which contribution was made;
3. The date that the covered Employee ceases to be in a class eligible for coverage;
4. The date the Employee transfers to coverage under a Health Maintenance Organization (HMO);
5. The termination date of the Group Health Plan;
6. The date the Employee dies;
7. In the event the Employer ceases to offer coverage for a particular type of group health insurance, they must provide notice to each Participant receiving this type of coverage at least ninety (90) days prior to said date; the Employer must offer to each Participant receiving this type of coverage the option to purchase any other Health Insurance Coverage currently being offered by the Employer, and the Employer must act uniformly without regard to the claims experience of those sponsors or any Health Status Related Factor relating to any Participants covered or new Participants who may become eligible for such coverage.

B. TERMINATION OF COVERED DEPENDENT'S COVERAGE

Except as provided in the Plan of Benefit's continuation provision coverage will terminate on the earliest of the following occurrences:

1. The day on which the covered Employee's coverage is terminated;
2. At the end of the period for which contributions were made by the covered Employee for the covered Dependent;
3. The date the covered Employee ceases to be in a class eligible for Dependent coverage;
4. The date the covered Dependent ceases to meet the definition of a Dependent;
Termination for a Dependent Child who is no longer an eligible student will occur on the earliest of the following:
 - a. The date of graduation;
 - b. The date he or she stops attending school full-time, if cessation is not due to Illness or Injury;
 - c. If a covered student Dependent is unable to attend school full-time because of Illness or Injury, the Plan of Benefits will continue the coverage until the first day of the next regular semester or quarter following the cessation of full-time attendance;
 - d. The date he or she reaches the maximum student age stated in the "Eligibility" section of this Plan of Benefits;
 - e. The date on which he or she is married.
5. The date the covered Dependent becomes eligible as a covered Employee;
6. The date Dependent coverage is discontinued under the Plan of Benefits;
7. The termination date of the Plan of Benefits.

C. RETURN TO WORK

An Employee who returns to work **within three (3) months** of a layoff or an approved leave of absence will retain the same insurance status as prior to the said date, provided any required contributions have been paid in full. No

new Pre-existing Condition Exclusion Waiting Period or eligibility Waiting Period will apply unless these conditions were still to be met at the time of lay-off or leave of absence.

An employee who returns to work **after three (3) months** of an approved leave of absence or layoff will be considered a new Employee and will be subject to all eligibility requirements, including all requirements relating to the Effective Date of coverage and the Pre-existing Condition provisions (except as provided under the provision entitled “status change”).

D. STATUS CHANGE

If an employee or Dependent has a status change while covered under this Plan of Benefits (i.e. Employee to Dependent, COBRA to active) and no interruption in coverage has occurred, the Plan of Benefits will allow continuity of coverage with respect to any Pre-existing Condition provisions and Waiting Period.

WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998

Coverage for Re-constructive Surgery Following Mastectomies

This Plan of Benefits provides medical and surgical benefits with respect to a mastectomy. In a case of a beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

- A. Reconstruction of the breast on which the mastectomy has been performed;
- B. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- C. Prosthesis and physical complications at all stages of mastectomy, including lymphedemas.

The Plan of Benefit’s Benefit Year Deductible and Co-payment will apply to these benefits.

FAMILY AND MEDICAL LEAVE ACT (“FMLA”)

The Group Health Plan shall at all times comply with FMLA as outlined in the regulations issued by the Department of Labor. During any leave taken under the FMLA, the Employer will maintain coverage under this Plan of Benefits on the same basis as coverage would have been provided if the Employee had been continuously employed during the entire leave period.

UNIFORMED SERVICES EMPLOYMENT and RE-EMPLOYMENT RIGHTS ACT (USERRA)

- A. In any case in which an Employee or any of such Employee's Dependents has coverage under the Plan of Benefits, and such Employee is not Actively at Work by reason of active duty service in the uniformed services, the Employee may elect to continue coverage under the Plan of Benefits as provided in this section. The maximum period of coverage of the Employee and such Employee's Dependents under such an election shall be the lesser of:
- i The twenty-four (24) month period beginning on the date on which the Employee's absence from being Actively at Work by reason of active duty service in the uniformed services begins; or
 - ii The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under USERRA.

The continuation of coverage period under USERRA will be counted toward any continuation of coverage period available under COBRA.

- B. An Employee who elects to continue coverage under this section of the Employer's Group Health Plan must pay one hundred and two percent (102%) such Employee's normal Premium. Except that, in the case of an Employee who performs service in the uniformed services for less than thirty-one (31) days, such Employee will pay the normal contribution for the thirty-one (31) days.
- C. An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Employer's Group Health Plan upon re-employment. Except as otherwise provided in this Article upon re-employment and reinstatement of coverage no new exclusion or Probationary Period will be imposed in connection with the reinstatement of such coverage if an exclusion or waiting period would normally have been imposed. This Article applies to the Employee who is re-employed and to a Dependent who is eligible for coverage under the Employer's Group Health Plan by reason of the reinstatement of the coverage of such Employee.
- D. This Section shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

SUBROGATION / RIGHT OF REIMBURSEMENT

In the event benefits provided to or on behalf of a Participant under the terms of this Plan of Benefits, the Participant agrees, as a condition of receiving benefits under the Plan of Benefits, to transfer to the Group Health Plan all rights to recover damages in full for such benefits when the Injury or Illness occurs through the act or omission of another person, firm, corporation, or organization. The Group Health Plan shall be subrogated, at its expense, to the rights of recovery of such Participant against any such liable third party.

If, however, the Participant receives a settlement, judgment, or other payment relating to an Injury or Illness from another person, firm, corporation, organization or business entity for the Injury or Illness, the Participant agrees to reimburse the Group Health Plan in full, and in first priority, for benefits paid by the Group Health Plan relating to the Injury or Illness. The Group Health Plan's right of recovery applies regardless of whether the recovery, or a portion thereof, is specifically designated as payment for, but not limited to, medical benefits, pain and suffering, lost wages, other specified damages, or whether the Participant has been made whole or fully compensated for his/her injuries.

The Group Health Plan's right of full recovery may be from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, underinsured motorist insurance, any medical payments (Med-Pay), no fault, personal Injury protection (PIP), malpractice, or any other insurance coverages which are paid or payable.

The Group Health Plan will not pay attorney's fees, costs, or other expenses associated with a claim or lawsuit without the expressed written authorization of the Group Health Plan.

The Participant shall not do anything to hinder the Group Health Plan's right of subrogation and/or reimbursement. The Participant shall cooperate with the Group Health Plan and execute all instruments and do all things necessary to protect and secure the Group Health Plan's right of subrogation and/or reimbursement, including assert a claim or lawsuit against the third party or any insurance coverages to which the Participant may be entitled. Failure to cooperate with the Group Health Plan will entitle the Group Health Plan to withhold benefits due the Participant under the Plan of Benefits Document. Failure to reimburse the Group Health Plan as required will entitle the Group Health Plan to deny future benefit payments for all Participants under this policy until the subrogation/reimbursement amount has been paid in full.

It is further agreed that the Participant will sign a written agreement to repay the Group Health Plan in full out of any money that the Participant receives from a negligent person or organization. If the Participant fails to sign such an agreement, the Group Health Plan reserves the right to withhold payment of the Participant's claims, which relate to the negligence of another person or organization, until such time as the Participant signs the agreement to repay.

WORKERS COMPENSATION PROVISION

This policy does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a Participant that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Participant. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Participant but the Participant elects exemption from available Workers' Compensation coverage; waives entitlement to Workers' Compensation benefits for which he/she is eligible; failed to timely file a claim for Workers' Compensation benefits; or, the Participant sought treatment for the injury or illness from a provider which is not authorized by the Participant's employer.

If the Employer Group Health Plan, or its designee, including PAI (hereinafter referred to as "the Plan") pays benefits for an injury or illness and the Plan determines the Participant also received Workers' Compensation benefits by means of a settlement, judgment, or other payment for the same injury or illness, Participant shall reimburse the Plan in full all benefits paid by the Plan relating to the injury or illness.

The Plan's right of recovery will be applied even if: the Workers' Compensation benefits are in dispute or are made by means of a compromised, doubtful and disputed, clincher or other settlement; no final determination is made that the injury or illness was sustained in the course of or resulted from the Participant's employment; the amount of Workers' Compensation benefits due to medical or health care is not agreed upon or defined by the Participant or the Workers' Compensation carrier; or, the medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

As a condition of receiving benefits under this Plan of Benefits, the Participant agrees to notify the Plan of any Workers' Compensation claim he/she may make and agrees to reimburse the Plan as described herein. The Participant shall not do anything to hinder the Plan's right of recovery. The Participant shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan's right of recovery, including assert a claim or lawsuit against the Workers' Compensation carrier or any other insurance coverages to which the Participant may be entitled. Failure to cooperate with the Plan will entitle the Plan to withhold benefits due the Participant under this Plan of Benefits. Failure to reimburse the Plan as required under this Section will entitle the Plan to invoke the Workers' Compensation Exclusion and deny payment for all claims relating to the injury or illness and/or deny future benefit payments for any such Participant until the reimbursement amount has been paid in full.

COORDINATION OF BENEFITS

This provision outlines the way benefits are payable when a Participant is covered under more than one Plan. It applies when a Participant is covered by this Plan of Benefits and also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plan pays a reduced benefit. This Plan of Benefits will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. Only the amount paid by the Plan of Benefits will be included for purposes of determining the maximums in the Schedule of Benefits. Through the coordination of benefits, a Participant or Dependent will not receive more than the Allowed Amounts for a loss.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. The Participant agrees to provide authorization to this Plan of Benefits to obtain information as to benefits or services available from any other plan or plans, or to recover over-payments. All benefits contained in the Plan of Benefits are subject to this provision.

When this Plan of Benefits is primary, its benefits are determined before those of the other plan. The benefits of the other plan are not considered. When this Plan of Benefits is secondary, its benefits are determined after those of the other plan. Its benefits may be reduced because of the other plan's benefits. When there are more than two plans this Plan of Benefits may be primary as to one and may be secondary as to another.

ORDER OF DETERMINATION

If a Participant covered hereunder is also covered for comparable benefits or services under another Plan which is the Primary Plan, benefits applicable under this Plan of Benefits will be reduced so that, for Benefits incurred, benefits available under all Plans shall not exceed the Allowable Expenses of such Benefits.

This Plan of Benefits determines its order of benefits using the first of the following, which applies:

- A. **General** - A Plan that does not coordinate with other Plans is always the Primary Plan;
- B. **Non-Dependent/Dependent** - The benefits of the Plan which covers the person as an Employee, (other than a Dependent) is the Primary Plan; the Plan which covers the person as a Dependent is the Secondary Plan;
- C. **Dependent Child/Parents Not Separated or Divorced** - Except as stated in (D) below, when this Plan of Benefits and another Plan cover the same child as a Dependent of different parents:
 - 1. The Primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The Secondary Plan is the Plan of the parent whose birthday falls later in the year; but
 - 2. If both parents have the same birthday, the benefits of the Plan which covered the parent the longer time is the Primary Plan; the Plan which covered the parent the shorter time is the Secondary Plan;
 - 3. If the other Plan does not have the birthday rule, but has the gender rule and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
- D. **Dependent Child/Separated or Divorced Parents** - If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - 1. First, the Plan of the parent with custody of the child;
 - 2. Then, the Plan of the spouse of the parent with custody;
 - 3. Finally, the Plan of the parent without custody of the child.

However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child, then that parent's Plan is the Primary Plan. If a court decree exists stating that the parents shall share joint custody, without stating that one of the parents is financially responsible for the health care of the child, the order of liability will be determined according to the rules for Dependent children whose parents are not separated or divorced. Anyone who legally adopts the child will assume natural parent status.

- E. **Active/Inactive Employee** - The Primary Plan is the Plan which covers the person as an Employee who is neither laid off or retired (or as that Employee's Dependents). The Secondary Plan is the Plan which covers that person as a laid off or retired employee (or as that Employee's Dependent). If the other Plan does not have this rule, and if, as result the Plans do not agree on the order of benefits, this rule does not apply.
- F. **Longer/Shorter Length of Coverage** - If none of the above rules determines the order of benefits, the Primary Plan is the Plan which covered an Employee longer. The Secondary Plan is the Plan which covered that person the shorter time.
- G. In the case of a Plan that contains order of benefit determination rules that declare that Plan to be excess to or **always secondary to all other Plans**, this Plan of Benefits will coordinate benefits as follows:
1. If this Plan of Benefits is Primary, it will pay or provide benefits on a Primary basis;
 2. If this Plan of Benefits is secondary, it will pay or provide benefits first, but the amount of benefits payable will be determined as if this Plan of Benefits were the Secondary Plan. The liability of this Plan of Benefits will be limited to such payment;
 3. If the Plan does not furnish the information needed by this Plan of Benefits to determine benefits within a reasonable time after such information is requested, this Plan of Benefits shall assume that the benefits of the other Plan are the same as those provided under this Plan of Benefits, and shall pay benefits accordingly. When information becomes available as to the actual benefits of the other Plan, any benefit payment made under this Plan of Benefits will be adjusted accordingly.

H. **Right To Coordination of Benefits Information**

The Plan Administrator and its Plan Supervisor have the right:

1. To obtain or share information with any insurance company or other organization regarding coordination of benefits without the claimant's consent; and
2. To require that the claimant provide the Plan Administrator with information on such other Plans so that this provision may be implemented;
3. To pay over the amount due under this Plan of Benefits to an insurer or other organization if this is necessary, in the Plan Administrator or its Plan Supervisor's opinion, to satisfy the terms of this provision.

I. **Facility of Payment**

Whenever payments which should have been made under this Plan of Benefits in accordance with this provision have been made under any other Plan or Plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organizations or person making such other payments any amount it will determine in order to satisfy the intent of this provision, and amount so paid will be deemed to be benefits paid under this Plan of Benefits and to the extent of such payment, the Plan Administrator will be fully discharged from liability under this Plan of Benefits. The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan of Benefits rather than the amount payable in the absence of this provision.

J. **Medicare**

If a retiree and age 65 or older, Medicare will be your primary plan.

Active Employees:

Active employees who are age 65 and over must elect either:

1. To participate in the Plan. If the employee elects to participate in the Plan, then the Plan will be the participant's primary medical coverage and Medicare will be the participant's secondary medical coverage; or
2. To not participate in the Plan. If the employee elects not to participate in the Plan, Medicare will provide the participant's only medical coverage.

The Dependent spouse, age 65 and over, of any active employee, must also make an election.

If the employee declines medical coverage under the Plan, such employee's Dependent spouse will not be eligible to participate in the Plan. If the employee elects to participate in the Plan, such employee's Dependent spouse may elect to either participate in the Plan or decline to participate in the Plan.

Retirees:

If retirees are eligible to participate in the Plan, the Plan is secondary to Medicare for any retirees who elect coverage under the Plan.

Coordination:

When Medicare is primary and the Plan is secondary, Medicare (Parts A and B) will be considered a plan for the purposes of coordination of benefits. The Plan will coordinate benefits with Medicare whether or not the participant or their covered Dependent spouse is/are actually receiving Medicare benefits.

MEDICARE FOR DISABLED BENEFICIARIES UNDER AGE 65*

The Group Health Plan is primary and Medicare will be secondary for the Covered Employee and their Covered Dependent spouse or child who is under age 65 and eligible for Medicare by reason of disability.

*For Plans with 100 or more employees. (If under 100 employees, Medicare is primary for disabled individuals).

MEDICARE FOR PERSON WITH END STAGE RENAL DISEASE (ESRD)

For Employees or Dependents under age 65 or 65 and over and still Actively at Work, if Medicare eligibility is due solely to End-Stage Renal Disease (ESRD), this Plan of Benefits will be primary during the first thirty (30) months of Medicare coverage. Thereafter, this Plan of Benefits will be secondary with respect to Medicare coverage. If an Employee or Dependent is age 65 or over, working and develops or is undergoing treatment for ESRD, Medicare will become primary as of the month they become entitled to ESRD benefits.

PRIVACY & SECURITY OF PROTECTED HEALTH INFORMATION

1. The Employer's Group Health Plan will disclose (or require PAI to disclose) Participant's PHI to the Employer only to permit the Employer to carry out plan administration functions for the Employer's Group Health Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Plan Sponsor will be subject to and consistent with the provisions of the sections below. Disclosure of Protected Health Information to Employer.
 - a. The Employer's Group Health Plan and any health insurance issuer or business associate servicing the Employer's Group Health Plan will disclose PHI to the Employer only to permit the Employer to carry out plan administration functions for the Employer's Group Health Plan not inconsistent with the requirements of the HIPAA and its implementing regulations, as amended. Any disclosure to and use by the Employer of PHI will be subject to and consistent with the provisions of paragraphs 2 and 3 of this section.
 - b. Neither the Employer's Group Health Plan nor any health insurance issuer or business associate servicing the Plan of Benefits will disclose Participant's PHI to the Employer unless the disclosures are explained in the Notice of Privacy Practices distributed to the Participants.
 - c. Neither the Employer's Group Health Plan nor any health insurance issuer or business associate servicing the Plan of Benefits will disclose Participant's PHI to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.
2. Restrictions on Employer's Use and Disclosure of Protected Health Information.
 - a. The Employer will neither use nor further disclose Participant's PHI, except as permitted or required by the Plan documents, as amended, or required by law.
 - b. The Employer will ensure that any agent, including any subcontractor, to whom it provides Participant's PHI, agrees to the restrictions and conditions of the Plan of Benefits, including this section, with respect to PHI.
 - c. The Employer will not use or disclose Participant PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.
 - d. The Employer will report to the Employer's Group Health Plan any use or disclosure of Participant PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
 - e. The Employer will make PHI available to the Participant who is the subject of the information in accordance with HIPAA.
 - f. The Employer will make PHI available for amendment, and will on notice amend Participant PHI, in accordance with HIPAA.
 - g. The Employer will track disclosures it may make of Participant PHI so that it can make available the information required for the Employer's Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.
 - h. The Employer will make available its internal practices, books, and records, relating to its use and disclosure of Participants' PHI, to the Group Health Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.
 - i. The Employer will, if feasible, return or destroy all Participant PHI, in whatever form or medium (including in any electronic medium under the Employer's custody or control), received from the Employer's Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the PHI, when the Participants' PHI is no longer needed for the Group Health Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Participant PHI, the Employer will limit the use or disclosure of any Participant PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.
3. Adequate Separation Between the Employer and the Employer's Group Health Plan.

- a. Certain classes of employees or other workforce members under the control of the Employer may be given access to Participant PHI received from the Employer's Group Health Plan or business associate servicing the Employer's Group Health Plan:
 - b. These employees will have access to PHI only to perform the plan administration functions that the Employer provides for the Employer's Group Health Plan.
 - c. These employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer, for any use or disclosure of Participant PHI in breach or violation of or noncompliance with the provisions of this section of the Plan of Benefits. The Employer will promptly report such breach, violation or noncompliance to the Employer's Group Health Plan and will cooperate with the Employer's Group Health Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.
 - d. Employer shall ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.
4. Employer Obligations to the security of Electronic Protected Health Information ("ePHI"):
- a. Where ePHI will be created, received, maintained or transmitted to or by the Employer on behalf of the Group Health Plan, the Employer shall reasonably safeguard the ePHI as follows:
 - b. Employer will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that the Employer creates, receives, maintains or transmits on behalf of the Employer's Group Health Plan;
 - c. Employer will ensure any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect this information;
 - d. The Employer shall report any security incident of which it becomes aware to the Employer's Group Health Plan as provided below:
 - i. In determining how and how often Employer shall report security incidents to Employer's Group Health Plan, both Employer and Employer's Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both Employer and Employer's Group Health Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the Parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of ePHI or interference with an information system:
 - Pings on a Party's firewall,
 - Port scans;
 - Attempts to log on to a system or enter a database with an invalid password or username,
 - Denial-of-service attacks that do not result in a server being taken off-line, and
 - Malware (e.g., worms, viruses).
 - ii. Employer shall, however, separately report to Employer's Group Health Plan (i) any successful unauthorized access, use, disclosure, modification, or destruction of the Group Health Plan's ePHI of which Employer becomes aware if such security incident either (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of Group Health Plan's ePHI; or (c) results in a breach of availability of Group Health Plan's ePHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after Employer becomes aware of the impact of such security incident upon Group Health Plan's ePHI.

GENERAL INFORMATION

Whereas Employer establishes this Group Health Plan and the applicable benefits, rights and privileges which shall pertain to participating employees, hereinafter referred to as "Employees" and the eligible Dependents of such Employees, as herein defined, for which benefits are provided through a fund established by the Employer and hereinafter referred to as the "Plan of Benefits".

PURPOSE

The purpose of this Plan of Benefits is to set forth the provisions of the Group Health Plan, which provide for the payment or reimbursement of all or a portion of eligible medical expenses. It is intended that the terms of this Plan of Benefits are legally enforceable and that the Plan of Benefits be maintained for the exclusive benefit of eligible Employees and their covered Dependents.

PLAN INTERPRETATION

The Plan Administrator has full discretionary authority to interpret and apply all Plan of Benefits provisions, including, but not limited to, all issues concerning eligibility and determination of benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Group Health Plan data, and perform other Group Health Plan connected services; however, final authority to construe and apply the provisions of the Plan of Benefits rests exclusively with the Plan Administrator. Decisions of the Plan Administrator, made in good faith, shall be final and binding.

CONTRIBUTIONS TO THE PLAN

The Employer shall from time to time evaluate the costs of the Group Health Plan and determine the amount to be contributed by the Employer (if any) and the amount to be contributed (if any) by each covered Employee. The Group Health Plan will notify employees in writing of any changes.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan of Benefits shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, exception or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Employer shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Employer, in its sole discretion, may terminate the interest of such Participant or former Participant, his spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Employer may determine, any such application shall be a complete discharge of all liability with respect to such benefit payment.

PLAN AMENDMENTS

This document contains all the terms of the Plan and may be amended from time to time by the Company. Any changes so made shall be binding on each Covered Participant and on any other participants referred to in this plan document.

TERMINATION OF PLAN

The Plan Administrator reserves the right at any time to terminate the Group Health Plan by a written instrument to that effect. All previous contributions by the Plan Administrator shall continue to be issued for the purpose of paying benefits under the provisions of this Plan of Benefits with respect to claims arising before such termination, or shall be used for the purpose of providing similar health benefits to covered Employees, until all contributions are exhausted.

PLAN IS NOT A CONTRACT

This Plan of Benefits constitutes the entire Group Health Plan. The Plan of Benefits will not be deemed to constitute a contract of employment or give any Employee of the Employer the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any employee.

MISSTATEMENT OF AGE

If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverage or amounts of benefits, or both, for which the person is covered shall be adjusted in accordance with the covered individual's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Contributions and benefits will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

LEGAL ACTIONS

No action at law or in equity can be brought under the Group Health Plan until you have exhausted the administrative process (including the exhaustion of all appeals) as described in this booklet. No such action can be brought against the Group Health Plan more than six years after Plan Supervisor receives a claim.

ADMINISTRATIVE SERVICES ONLY

The Plan Supervisor provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Employer's Group Health Plan is a self-funded health plan and the Employer assumes all financial risk and obligation with respect to claims.

AMENDMENT

Upon thirty (30) days prior written notice, the Employer may unilaterally amend this Plan of Benefits.

CLERICAL ERRORS

Clerical errors by the Plan Supervisor or the Employer will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

IDENTIFICATION CARD

A Participant must present their Identification Card prior to receiving Benefits.

Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Participant whose Premium has been paid. Any person receiving Covered Expenses to which the person is not entitled will be responsible for the charges.

INFORMATION AND RECORDS

The Plan Supervisor and the Employer are entitled to obtain such medical and Hospital records as may reasonably be required from any Provider incident to the treatment, payment and healthcare operations for the administration of the Benefits hereunder and the attending Physician's certification as to the Medical Necessity for care or treatment.

NEGLIGENCE OR MALPRACTICE

The Plan Supervisor and Employer do not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Participant by a Provider is rendered or supplied by such Provider and not by the Plan Supervisor or the Employer. The Plan Supervisor and Employer are not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in rendering such medical treatment, service, Medical Supply or medication.

NOTICES

Except as otherwise provided in this Plan of Benefits, any notice under the Employer's Group Health Plan may be given by United States mail, postage paid and addressed:

1. To the Plan Supervisor:
Planned Administrators, Inc.
Post Office Box 6927
Columbia, South Carolina 29260

2. To a Participant: To the last known name and address listed for the Employee. Participants are responsible for notifying the Plan Supervisor of any name or address changes within thirty-one (31) days of the change.
3. To the Employer: To the name and address last given to the Plan Supervisor. The Employer is responsible for notifying the Plan Supervisor and Participants of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF RIGHTS

On occasion, the Plan Supervisor (on behalf of the Employer's Group Health Plan) or the Employer may, at their discretion, choose not to enforce all of the terms and conditions of this Plan of Benefits. Such a decision does not mean the Employer's Group Health Plan or Employer waives or gives up any rights under this Plan of Benefits in the future.

OTHER INSURANCE

Each Participant must provide the Employer's Group Health Plan (and its designee, including the Plan Supervisor) and Employer with information regarding all other health insurance coverage to which such Participant is entitled.

PAYMENT OF CLAIMS

A Participant is expressly prohibited from assigning any right to payment of Covered Expenses or any payment related to Benefits. The Employer's Group Health Plan may pay all Covered Expenses directly to the Employee upon receipt of due proof of loss. Where a Participant has received Benefits from a Participating Provider or Contracting Provider, the Employer's Group Health Plan will pay Covered Expenses directly to such Participating Provider or Contracting Provider.

PHYSICAL EXAMINATION

The Employer's Group Health Plan has the right to examine, at their own expense, a Participant whose injury or sickness is the basis of a claim (whether Pre-Service, Post-Service, Concurrent or Urgent Care). Such physical examination may be made as often as the Employer's Group Health Plan (through its designee, including the Plan Supervisor) may reasonably require while such claim for Benefits or request for Pre-Authorization is pending.

DEFINITIONS

Capitalized terms that are used in this Plan of Benefits shall have the following defined meanings:

“Actively at Work”: a permanent, full-time employee who works at least the minimum number of hours per week and the minimum number of weeks per year (each as set forth in the ELIGIBILITY section) and who is not absent from work during the initial enrollment period because of a leave of absence or temporary lay-off. An absence during the initial enrollment period due to a Health Status Related Factor will not keep an employee from qualifying for Actively at Work status.

“Admission”: the period of time between a Participant’s entry as a registered bed-patient into a Hospital or Skilled Nursing Facility and the time the Participant leaves or is discharged.

“Adverse Benefit Determination”: any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial reduction, termination, or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a plan, and including, a denial reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

“Allowed Amount”: the amount payable under this Plan of Benefits with respect to particular Benefits. The Allowed amount is based on:

- a. The actual charges made for similar services, supplies or equipment by Providers and filed with the Plan Supervisor during the preceding calendar year;
- b. The Allowed Amount for the preceding year increased by an index based on national or local economic factors or indices; or
- c. The lowest rate at which any medical service, supply or equipment is generally available in the local service area when, in the judgment of the Plan Supervisor, charges for such service, supply or equipment generally should not vary significantly from one Provider to another, and which rate will be available to Participants upon written request; or
- d. An amount that has been agreed upon by a Provider and the network used by the Plan Supervisor; or
- e. An amount established by the Plan Supervisor in its sole discretion. In determining the Allowed Amount under this paragraph, the Plan Supervisor may, through its medical staff and/or consultants, determine the Allowed Amount based on a number of factors, including, for example, comparable or similar services or procedures.

“Ambulatory Surgical Center”: a licensed facility that:

- a. has permanent facilities equipped and operated primarily for the purpose of performing surgical procedures on an outpatient basis; and
- b. has continuous Physician services and registered professional nursing service whenever a patient is in the facility; and
- c. does not provide accommodations for patients to stay overnight; and
- d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or oral surgeon.

Ambulatory Surgical Center includes an endoscopy center.

“Benefit Year”: the period of time set forth on the Schedule of Benefits. The initial Benefit Year may be more or less than twelve (12) months.

“Benefit Year Deductible”: the amount, if any, listed on the Schedule of Benefits that must be paid by the Participant each Benefit Year before Employer’s Group Health Plan will pay Covered Expenses. The Benefit Year Deductible is subtracted from the Allowable Charge before Coinsurance is calculated. Participants must refer to the Schedule of Benefits to determine if the Benefit Year Deductible applies to the Out-of-Pocket Maximum.

“Benefits”: medical services or Medical Supplies that are:

- a. Medically Necessary; and,
- b. Pre-Authorized (when required under this Plan of Benefits or the Schedule of Benefits); and,
- c. Included in this Plan of Benefits; and,
- d. Not limited or excluded under the terms of this Plan of Benefits.

“Brand Name Drug”: a Prescription Drug that is manufactured under a registered trade name or trademark.

“Certificate of Creditable Coverage”: a document from a Group Health Plan or insurer that states that a Participant had prior Creditable Coverage with that Group Health Plan or insurer.

“Child”: An Employee’s unmarried child, whether a natural child, adopted child, foster child, stepchild, or child for whom an Employee has custody or legal guardianship and for whom the Employee provides at least fifty-one (51%) of the child’s support and resides with employee more than half of each calendar year.

The term “Child” also includes an Incapacitated Dependent, a child of a divorced or divorcing Employee who has a right to enroll in the Employer’s Group Health Plan under a Qualified Medical Child Support Order. A child who is (or was) married will not be entitled to coverage, notwithstanding the termination of such marriage.

“Coinsurance”: the sharing of Covered Expenses between the Participant and the Employer’s Group Health Plan. After the Participant’s Benefit Year Deductible requirement is met, the Employer’s Group Health Plan will pay the percentage of Allowable Charges as set forth on the Schedule of Benefits. The Participant is responsible for the remaining percentage of the Allowable Charge. Coinsurance is calculated after any applicable Benefit Year Deductible or Co-payment is subtracted from the Allowable Charge based upon the network charge or lesser charge of the Provider.

For Prescription Drug Benefits, Coinsurance means the amount payable by the Participant calculated as follows:

1. The percentage listed on the Schedule of Benefits; multiplied by,
2. The amount listed in the Participating Provider’s schedule of allowance for that item calculated at the time of sale;
3. Without regard to any Credit or allowance that may be received by PAI.

“Concurrent Care Claim”: an ongoing course of treatment to be provided over a period of time or number of treatments.

“Continued Stay Review”: the review that must be obtained by a Participant (or the Participant’s representative) regarding an extension of an Admission to determine if an Admission for longer than the time that was originally Pre-Authorized is Medically Necessary (when required).

“Co-payment”: the amount payable by the Participant each time the Participant receives a Covered Service subject to a Co-payment as shown on the Schedule of Benefits.

“Covered Expenses”: the amount payable by the Employer’s Group Health Plan for Benefits. The amount of Covered Expenses payable for Benefits is determined as set forth in this Plan of Benefits and at the percentages set forth in the Schedule of Benefits. Covered Expenses are subject to the limitations and requirements set forth in the Plan of Benefits and on the Schedule of Benefits. Covered Expenses will not exceed the Allowable Charge.

“Creditable Coverage”: benefits or coverage provided under any of the following (each capitalized term as defined under HIPAA unless defined in this Plan of Benefits):

- a. A Group Health Plan;

- b. Health Insurance Coverage;
- c. Medicare: Part A or Part B, Title XVIII of the Social Security Act;
- d. Medicaid: Title XIX of the Social Security Act—Other than coverage consisting solely of benefits under Section 1928;
- e. Title 10 United States Code Chapter 55 (i.e. medical and dental care for members and certain former members of the uniformed forces and their Dependents);
- f. A medical care program of the Indian Health Service or of a tribal organization;
- g. A state health benefits risk pool [including South Carolina Health Insurance Pool (SCHIP)];
- h. A state Children’s Health Insurance Program (S-CHIP);
- i. A health plan offered under Chapter 89 of Title 5, United States Code (the Federal Employee Health Benefits Act);
- j. A public health plan, including that of the U.S. Federal Government as well as that of a foreign country or its political subdivision; or
- k. A health benefit plan under Section 5(e) of 22 United States Code 2504(e), the Peace Corps Act.

Creditable Coverage does not include coverage consisting solely of Excepted Benefits (as defined within the definition of Health Insurance coverage).

“Dependent”: an individual who is:

- a. An Employee’s spouse; or
- b. A Child under the age set forth on the Schedule of Benefits; or
- c. A Child who is over the age set forth in this Plan of Benefits, but who has not reached the age of termination of Benefits as set forth on the Schedule of Benefits, and is enrolled in and is attending (with attendance qualifying such Child as a full-time student under the rules of the institution) one of the following:
 - 1. High school; or
 - 2. An accredited or licensed school commonly recognized as a vocational, technical or trade school; or
 - 3. An accredited college or university; or
- d. An Incapacitated Dependent.

The time period between graduation from high school and college entry, or between college graduation and graduate school entry, will be covered only if the Child has applied for admission beginning with the next regular semester immediately following graduation.

When requested by the Employer’s Group Health Plan, the Employee will furnish written proof (in the form of a certificate on the applicable school’s letterhead) that the Dependent qualifies as a full-time student.

“Discount Services”: services (including discounts on services) that are not Benefits, but which may be offered to Participants from time to time as a result of being a Participant.

“Durable Medical Equipment”: equipment that:

- a. Can stand repeated use; and,
- b. Is Medically Necessary, and,
- c. Is customarily used for the treatment of a Participant’s illness, injury, disease or disorder; and,
- d. Is appropriate for use in the home; and,
- e. Is not useful to a Participant in the absence of illness or injury; and
- f. Does not include appliances that are provided solely for the Participant’s comfort or convenience; and,
- g. Is a standard, non-luxury item (as determined by the Employer’s Group Health Plan); and

h. Is ordered by a medical doctor, oral surgeon, podiatrist, or osteopath.

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment. Items such as air conditioners, de-humidifiers, whirlpool baths, and other equipment which have non-therapeutic uses are not considered Durable Medical Equipment.

“Emergency Admission Review”: the review that must be obtained by a Participant (or the Participant’s representative) within twenty-four (24) hours of or by the end of the first working day after the commencement of an Admission to a Hospital to treat an Emergency Medical Condition.

“Emergency Medical Condition”: a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- a. Placing the health of the Participant, or with respect to a pregnant Participant, the health of the Participant or her unborn child, in serious jeopardy; or
- b. Serious impairment to bodily functions; or
- c. Serious dysfunction of any bodily organ or part.

“Employee”: an individual who is eligible for coverage as provided in the eligibility section of this Plan of Benefits, and who is so designated to the PAI by the Employer.

“Employer”: the entity providing this Plan of Benefits.

“Employer’s Effective Date”: the date PAI begins to provide services under this Plan of Benefits.

“Employer’s Group Health Plan”: the Group Health Plan adopted by the Employer as the Plan Sponsor. This Plan of Benefits outlines certain terms of the Employer’s Group Health Plan.

“Enrollment Date”: the first day of coverage in the Employer’s Group Health Plan or the first day of the Waiting Period for enrollment, whichever is earlier.

“Experimental or Investigational”: surgical procedures or medical procedures, supplies, devices or drugs which, at the time provided, or sought to be provided, are in the judgment of PAI not recognized as conforming to generally accepted medical practice, or the procedure, drug or device:

- a. Has not received required final approval to market from appropriate government bodies; or,
- b. Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes; or,
- c. Is not demonstrated to be as beneficial as established alternatives; or,
- d. Has not been demonstrated to improve net health outcomes; or,
- e. Is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

“Excepted Benefits”: benefits or coverage that do not constitute Creditable Coverage including the following:

- a. Coverage only for accident, or disability income insurance, or any combination thereof;
- b. Coverage issued as a supplement to liability insurance;
- c. Liability insurance, including general liability insurance and automobile liability insurance;
- d. Worker’s compensation or similar insurance;
- e. Automobile medical payment insurance;
- f. Credit-only insurance;

- g. Coverage for on-site medical clinics;
- h. Other similar insurance coverage specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

If offered separately:

- a. Limited scope dental or vision benefits;
- b. Benefits for long-term care, nursing home care, Home Health Care, community-based care, or any combination thereof;
- c. Such other similar, limited benefits as specified in regulations.

If offered as independent, non-coordinated benefits:

- a. Coverage only for a specified disease or illness;
- b. Hospital indemnity or other fixed indemnity insurance.

If offered as a separate insurance policy:

- a. Medicare supplemental health insurance (as defined under Section 1882(g)(1) of the Social Security Act);
- b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code;
- c. Similar supplemental coverage under a Group Health Plan.

“Generic Drug”: a Prescription Drug that has a chemical structure that is identical to and has the same bio-equivalence as a Brand Name Drug but is not manufactured under a registered brand name or trademark or sold under a brand name. The Pharmacy Benefit Manager has the discretion to determine if a Prescription Drug is a Generic Drug.

“Genetic Information”: information about genes, gene products (messenger RNA and transplanted protein) or genetic characteristics derived from a Participant or family member of the Participant. Genetic Information includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes. However, Genetic Information shall not include routine physical measurements, chemical, blood, and urine analyses unless conducted to diagnose a genetic characteristic; tests for abuse of drugs; and tests for the presence of human immunodeficiency virus.

“Grace Period”: a period of time as determined by the Employer that allows for the Participant to pay any premium due.

“Group Health Plan”: an employee welfare benefit plan to the extent that such plan provides health benefits to employees or their dependents, as defined under the terms of such Group Health Plan, directly or through insurance, reimbursement or otherwise. This Plan of Benefits established by the Employer is a Group Health Plan.

“Health Insurance Coverage”: benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any Hospital or medical service policy or certificate, Hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. Health Insurance Coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

“Health Status Related Factor”: any of the following factors: health status, medical conditions, (including both physical and mental illnesses), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

“HIPAA”: the Health Insurance Portability and Accountability Act of 1996, as amended.

“Home Health Agency”: an agency or organization licensed by the appropriate state regulatory agency to provide Home Health Care.

“Home Health Care”: part-time or intermittent nursing care, health aide services, or physical, occupational, or speech therapy provided or supervised by a Home Health Agency and provided to a home-bound Participant in such Participant’s private residence.

“Hospice Care”: care for terminally ill patients under the supervision of a Physician, and is provided by an agency that is licensed or certified as a hospice or hospice care agency by the appropriate state regulatory agency.

“Hospital”: a short-term, acute care facility licensed as a hospital by the state in which it operates. A Hospital is primarily engaged in providing medical, surgical, or acute behavioral health diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of licensed Physicians, and continuous twenty-four (24) hour-a-day services by licensed, registered, graduate nurses physically present and on duty. The term Hospital does not include Long Term Acute Care Hospitals, chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Hospital. A Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat Participants.

“Identification Card”: the card issued by PAI to a Participant that contains the Participant’s identification number.

“Incapacitated Dependent”: a Child who is:

1. Incapable of financial self-sufficiency by reason of mental or physical disability; and,
2. Dependent upon the Employee for at least fifty-one (51) percent of his or her support and maintenance.

A Child must meet both of these requirements to qualify as an Incapacitated Dependent. The Employee will update items (1) and (2) each year or upon PAI’s request. A Child who is not incapacitated by the maximum Dependent Child age listed on the Schedule of Benefits will not be covered.

“Late Enrollee”: a Participant under a Group Health Plan who enrolls under the Group Health Plan other than during:

- a. The first period in which he or she is eligible to enroll under the Group Health Plan if the initial enrollment period is a period of at least thirty (30) days; or
- b. A Special Enrollment period.

“Lifetime Maximum”: the total Benefits under this Group Health Plan to which a Participant is entitled during such Participant’s lifetime.

“Mail Service Pharmacy”: a Pharmacy maintained by the Pharmacy Benefit Manager that fills prescriptions and sends Prescription Drugs by mail.

“Maternity Management Program”: the voluntary program offered by the Employer’s Group Health Plan to Participants who are pregnant.

“Maximum Payment”: the maximum amount the Employer’s Group Health Plan will pay for a particular Benefit. The Maximum Payment will not be affected by any Credit. The Maximum Payment will be one of the following as determined by PAI in its discretion:

- a. The actual charges made for similar services, supplies or equipment by Providers and filed with the Plan Supervisor during the preceding calendar year;
- b. The Maximum Payment for the preceding year increased by an index based on national or local economic factors or indices; or
- c. The lowest rate at which any medical service, supply or equipment is generally available in the local service area when, in the judgment of the Plan Supervisor, charges for such service, supply or equipment generally should not vary significantly from one Provider to another, and which rate will be available to Participants upon written request; or
- d. An amount that has been agreed upon by a Provider and the network used by the Plan Supervisor; or

- e. An amount established by the Plan Supervisor in its sole discretion. In determining the Maximum Payment under this paragraph, PAI may, through its medical staff and/or consultants, determine the Maximum Payment based on a number of factors, including, for example, comparable or similar services or procedures.

“Medical Child Support Order”: any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency which:

1. Provides child support with respect to a Child or provides for health benefit coverage to a Child, is made pursuant to a state domestic relations law (including a community property law), and relates to the Plan of Benefits;
2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.
3. A Medical Child Support Order must clearly specify:
 - a. The name and the last known mailing address (if any) of each participant Employee and the name and mailing address of each Alternate Recipient covered by the order; and,
 - b. A reasonable description of the type of coverage to be provided by the Group Health Plan to each such Alternate Recipient or the manner in which such type of coverage is to be determined; and,
 - c. The period to which such order applies; and,
 - d. Each Group Health Plan to which such order applies.
4. If the Medical Child Support Order is a national medical support notice, the order must also include:
 - a. The name of the issuing agency; and,
 - b. The name and mailing address of an official or agency that has been substituted for the mailing address of any Alternate Recipient; and,
 - c. The identification of the underlying Medical Child Support Order.
5. A Medical Child Support Order meets the requirement of this definition only if such order does not require a Group Health Plan to provide any type or form of the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section of 13822 of the Omnibus Budget Reconciliation Act of 1993).

“Medically Necessary/Medical Necessity”: health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

- a. in accordance with generally accepted standards of medical practice;
- b. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s Illness, Injury or disease; and
- c. not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s Illness, Injury or disease.

For the purposes of “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

“Medical Supplies”: supplies that are:

1. Medically Necessary; and,
2. Prescribed by a Physician acting within the scope of his or her license (or are provided to a Participant in a Physician’s office); and,
3. Are not available on an over-the-counter basis (unless such supplies are provided to a Participant in a Physician’s office and should not (in PAI’s discretion) be included as part of the treatment received by the Participant); and

4. Are not prescribed in connection with any treatment or benefit that is excluded under this Plan of Benefits.

“Mental Health Conditions”: certain psychiatric disorders or conditions defined in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and which is not otherwise excluded by the terms and conditions of this Plan of Benefits. The conditions as mandated by the State of South Carolina are:

1. Bipolar Disorder;
2. Major Depressive Disorder;
3. Obsessive Compulsive Disorder;
4. Paranoid and Other Psychotic Disorder;
5. Schizoaffective Disorder;
6. Schizophrenia;
7. Anxiety Disorder;
8. Post-traumatic Stress Disorder; and
9. Depression in childhood and adolescence.

“Mental Health Services”: treatment (except Substance Abuse Services) that is defined, described or classified as a psychiatric disorder or condition in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and which is not otherwise excluded by the terms and conditions of this Plan of Benefits.

“Midwife”: a person who is certified or licensed to assist women in the act of childbirth.

“Milieu Therapy”: type of treatment in which the patient’s social environment is manipulated for his/her benefit.

“Natural Teeth”: teeth that:

1. Are free of active or chronic clinical decay; and,
2. Have at least 50% bony support; and,
3. Are functional in the arch; and,
4. Have not been excessively weakened by multiple dental procedures; or,
5. Teeth that have been treated for one (1) or more of the conditions referenced in 1-4 above, and as a result of such treatment have been restored to normal function.

“Non-Participating Provider”: any Provider who does not have a current, valid contract with one of the networks used by this Plan of Benefits.

“Non-Preferred Drug”: a Prescription Drug that bears a recognized brand name of a particular manufacturer but does not appear on the list of Preferred Brand Drugs and has not been chosen by PAI or its designated Pharmacy Benefit Manager to be a Preferred Drug, including any Brand Name Drug with an “A” rated Generic Drug available.

“Orthopedic Device”: any ridged or semi-ridged leg, arm, back or neck brace and casting materials that are directly used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

“Orthotic Device”: any device used to mechanically assist, restrict, or control function of a moving part of the Participant’s body.

“Over-the-Counter Drug”: a drug that does not require a prescription.

“Participant”: an Employee or Dependent who has enrolled (and qualifies for coverage) under this Plan of Benefits.

“Participant Effective Date”: the date on which a Participant is covered for Benefits under the terms of this Plan of Benefits.

“Participating Provider”: a Physician, Hospital, or other Provider who has a signed contract with one of the networks used by this Plan of Benefits and who has agreed to provide Benefits to a Participant and submit claims to PAI and to accept the Allowed Amount as payment in full for Benefits. The participating status of a Provider may change.

“Pharmacy”: a licensed establishment where prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

“Physician”: a person who is:

1. Not an:
 - a. Intern; or,
 - b. Resident; or,
 - c. In-house physician; and,
2. Duly licensed by the appropriate state regulatory agency as a:
 - a. Medical doctor; or,
 - b. Oral surgeon; or,
 - c. Osteopath; or,
 - d. Podiatrist; or,
 - e. Chiropractor; or,
 - f. Optometrist; or,
 - g. Psychologist with a doctoral degree in psychology; and,
3. Legally entitled to practice within the scope of his or her license; and
4. Customarily bills for his or her services.

“Physician Services”: the following services, performed by a Physician within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards as determined by PAI:

1. Office visits, which are for the purpose of seeking or receiving care for an illness or injury; or,
2. Basic diagnostic services and machine tests;
3. Physician Services includes the following services when performed by a medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, or licensed psychologist with a doctoral degree:
 - a. Benefits rendered to a Participant in a Hospital or Skilled Nursing Facility; or,
 - b. Benefits rendered in a Participant’s home; or,
 - c. Surgical Services; or,
 - d. Anesthesia services, including the administration of general or spinal block anesthesia; or,
 - e. Radiological examinations; or,
 - f. Laboratory tests; or,
 - g. Maternity services, including consultation, prenatal care, conditions directly related to pregnancy, delivery and postpartum care, and delivery of one or more infants. Physician Services also include maternity services performed by certified nurse midwives.

“Plan”: any program that provides benefits or services for medical or dental care or treatment including:

1. Individual or group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage; and
2. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan for purposes of this Plan of Benefits. If a Plan has two (2) or more parts and the coordination of benefit rules apply only to one (1) of the parts, each part is considered a separate Plan.

“Plan Administrator”: the entity charged with the administration of the Plan of Benefits. The Employer is the Plan Administrator of this Plan of Benefits.

“Plan of Benefits”: the document outlining the coverage provided under the Employer’s Group Health Plan. This Plan of Benefits includes the Schedule of Benefits and all endorsements, amendments, riders or addendums.

“Plan of Benefits Effective Date”: 12:01 A.M. on the date listed on the Schedule of Benefits.

“Post-Service Claim”: any claim that is not a Pre-Service Claim.

“Pre-Admission Review”: the review that must be obtained by a Participant (or the Participant’s representative) prior to all Admissions that are not related to an Emergency Medical Condition.

“Pre-Authorized/Pre-Authorization”: the approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Participant. Pre-Authorization means only that the Benefit is Medically Necessary. Pre-Authorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Participant. Notwithstanding Pre-Authorization, payment for Benefits is subject to a Participant’s eligibility, Pre-Existing Condition Limitations and all other limitations and exclusions contained in this Plan of Benefits. A Participant’s entitlement to Benefits is not determined until the Participant’s claim is processed.

“Pre-existing Condition(s)”: a physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was received or recommended during the six (6) month period preceding the Enrollment Date, if applicable. Genetic Information may not be treated as a Pre-Existing Condition in the absence of a diagnosis of the specific condition related to the Genetic Information.

“Pre-existing Condition Exclusion Period”: the period during which this Plan of Benefits will not provide benefits to a Participant for Pre-Existing Conditions, not to exceed twelve (12) months (eighteen (18) months for late enrollees).

“Preferred Brand Drug”: a Prescription Drug that bears a recognized brand name of a particular manufacturer and appears on the list of Preferred Brand Drugs.

“Preferred Drug”: a Prescription Drug that has been reviewed for cost effectiveness, clinical efficacy and quality that is preferred by the Pharmacy Benefit Manager, for dispensing to Participants. Preferred Drugs are subject to periodic review and modification by PAI, or its designated Pharmacy Benefit Manager, and include Brand Name Drugs and Generic Drugs.

“Premium”: the monthly amount paid to the Employer by the Participant for coverage under this Plan of Benefits. Payment of Premiums by the Participant constitutes acceptance by the Participant of the terms of this Plan of Benefits.

“Pre-service Claim”: any claim or request for a Benefit where prior authorization or approval must be obtained from Blue Cross Medical Review Department before receiving the medical care, service or supply. An approval means only that a service is Medically Necessary for treatment of your condition, but is not a guarantee or verification of Benefits.

Payment is subject to your eligibility, Pre-existing Condition limitations and all other Plan of Benefits limitations and exclusions. A Final Benefit determination will be made when your claim is processed.

“Prescription Drugs”: a drug or medicine that is:

- a. Required to be labeled that it has been approved by the Food and Drug Administration; and,
- b. Bears the legend “Caution: Federal Law prohibits dispensing without a prescription” or “Rx Only” prior to being dispensed or delivered, or labeled in a similar manner; or,
- c. Insulin.

Additionally, to qualify as a Prescription Drug, the drug must

- a. Be ordered by a medical doctor or oral surgeon as a prescription; and,
- b. Not be entirely consumed at the time and place where the prescription is dispensed; and,
- c. Be purchased for use outside a Hospital.

Prescription Drugs also include the following which may not otherwise meet the definition of Prescription Drugs:

- a. DESI drugs --These drugs are determined by the FDA (Food and Drug Administration) as lacking substantial evidence of effectiveness. The DESI drugs do not have studies to back up the medications’ uses, but since they have been used and accepted for many years without any safety problems, they continue to be used in today’s market place.
- b. Controlled substance 5 (CV) OTC’s are covered. (Examples: Robitussin AC syrup and Naldecon-CX) Federal law designates these medications as OTC. However, depending on certain state Pharmacy laws, the medications may be considered Prescription Medications and are, therefore, all covered.
- c. Single entity vitamins - These vitamins have indications in addition to their use as nutritional supplements. For this reason, Plan Supervisor recommends covering these medications. Single entity vitamins are used for the treatment of specific vitamin deficiency diseases. Some examples include: vitamin B12 (cyanocobalamin) for the treatment of pernicious anemia and degeneration of the nervous system, vitamin K (phytonadione) for the treatment of hypoprothrombinemia or hemorrhage, and folic acid for the treatment of megaloblastic and macrocytic anemias.

“Prescription Drug Co-payment”: the amount payable, if any, set forth on the Schedule of Benefits, by the Participant for each Prescription Drug filled or refilled. This amount will not be applied to the Benefit Year Deductible or the Out-of-Pocket Maximum.

“Primary Plan”: the plan with primary responsibility for the Participants claims as determined by the coordination of benefit provisions of this Plan of Benefits.

“Protected Health Information (PHI)”: individually identifiable health information collected electronically, orally, or via paper. PHI includes information such as the patient’s name, social security number, telephone number, medical record number, address, including ZIP code as well as medical records.

“Provider”: any person or entity licensed by the appropriate state regulatory agency and legally engaged within the scope of such person or entity’s license in the practice of any of the following:

- | | |
|-------------------------|------------------------|
| ◆ Medicine | ◆ Physical Therapy |
| ◆ Dentistry | ◆ Behavioral Health |
| ◆ Optometry | ◆ Oral Surgery |
| ◆ Podiatry | ◆ Speech Therapy |
| ◆ Chiropractic Services | ◆ Occupational Therapy |

Provider includes a Long Term Care Hospital, a Hospital, a Rehabilitation Facility, Skilled Nursing Facility, and nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a medical doctor or oral surgeon. The term Provider does not include physical trainers, lay midwives or masseuses.

“Qualified Medical Child Support Order (QMCSO)”: a Medical Child Support Order that:

1. Creates or recognizes the existence of an Alternate Recipient’s right to enroll under this Plan of Benefits; or,
2. Assigns to an Alternate Recipient the right to enroll under this Plan of Benefits.

“Qualifying Event”: for continuation of coverage purposes, a Qualifying Event is any one of the following:

1. Termination of the Employee’s employment (other than for gross misconduct) or reduction of hours worked that renders the Employee no longer Actively at Work and therefore ineligible for coverage under the Plan of Benefits;
2. Death of the Employee;
3. Divorce or legal separation of the Employee from his or her spouse;
4. A Child ceasing to qualify as a Dependent under this Plan of Benefits;
5. Entitlement to Medicare by an Employee, or by a parent of a Child;
6. A proceeding under Title II of COBRA with respect to the Employer from whose employment an Employee retired at any time.

“Schedule of Benefits”: the pages of this Plan of Benefits so titled which specify the coverage provided and the applicable Co-payments, Coinsurance, Benefit Year Deductibles, and Benefit limitations.

“Second Opinion”: an opinion from a Physician regarding a service recommended by another Physician before the service is performed, to determine whether the proposed service is Medically Necessary and covered under the terms of this Plan of Benefits.

“Secondary Plan”: the Plan that has secondary responsibility for paying a Participant’s claim as determined through the coordination of benefits provisions of this Plan of Benefits.

“Skilled Nursing Facility”: an institution other than a Hospital that is certified and licensed by the appropriate state regulatory agency as a skilled nursing facility.

“Special Enrollment”: the time period during which an Employee or eligible Dependent who is not enrolled for coverage under this Group Health Plan may enroll for coverage due to the involuntary loss of other coverage or under circumstances described in the Eligibility For Coverage section of this Plan of Benefits.

“Specialist”: a Physician that specializes in a particular branch of medicine.

“Specialty Drugs”: Prescription Drugs that treat a complex clinical condition and/or require special handling such as refrigeration. They generally require complex clinical monitoring, training and expertise. Specialty drugs include, but are not limited to infusible specialty drugs for chronic diseases, injectable and self-injectable drugs for acute and chronic diseases, and specialty oral drugs. Specialty drugs are used to treat acute and chronic disease states (e.g. growth deficiencies, Hemophilia, Multiple Sclerosis, Rheumatoid Arthritis, Gaucher's Disease, Hepatitis, cancer, organ transplantation, Alpha 1-Antitrypsin Disease and immune deficiencies).

“Substance Abuse”: the continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use (as defined, described or classified in the most current version of *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association).

“Substance Abuse Services”: services or treatment relating to Substance Abuse.

“Transplant Benefit Period”: the period of time which for transplant of:

- a. an organ, the period which begins one day prior to the Admission date for transplant and continues for a 12 month period. Anti-rejection drugs are not subject to the Transplant Benefit Period; or
- b. bone marrow, the period which begins one day prior to the date marrow ablative therapy begins, or one day prior to the day the preparative regimen for non-myeloablative transplant begins and continues for a twelve (12) month

period. Mobilization therapy and stem cell harvest are also included. Anti-rejection drugs are not subject to the Transplant Benefit Period.

“Transplant Lifetime Maximum”: the maximum amount of Benefits provided in a Lifetime for each of the transplants listed in the Medical Schedule of Benefits. Once the Transplant Lifetime Maximum has been met, no additional transplant benefits will be provided for that type of transplant. Anti-rejection drugs are not subject to the Transplant Lifetime Maximum, but are subject to the Lifetime Maximum referenced within the Medical Schedule of Benefits.

“Totally Disabled”: applied to a Participant means the complete inability of the Participant to perform the important daily duties of the Participant’s occupation, for which the Participant is reasonably suited by education, training or experience. As applied to a Participant who is a Dependent, the term means the Dependent is prevented solely because of a non-occupational Injury or non-occupational disease from engaging in all of the normal activities of a person in good health and of like age.

“Urgent Care”: treatment required in order to treat an unexpected Illness or Injury that is life-threatening and required in order to prevent a significant deterioration of the Participant’s health if treatment were delayed.

“Urgent Care Claim”: any claim for medical care or treatment where making a determination under other than normal time frames could seriously jeopardize the Participant’s life or health or the Participant’s ability to regain maximum function; or, in the opinion of a medical doctor or oral surgeon with knowledge of the Participant’s medical condition, would subject the Participant to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

“Waiting Period”: a period of continuous employment with the Employer that an Employee must complete before becoming eligible to enroll in the Plan of Benefits.

INDEX

A

Accidental Injury, 6, 15, 23
Actively at Work, 26, 28, 33, 38, 44, 55
Admission, 5, 16, 17, 18, 44, 45, 55
Adverse Benefit Determination, 8, 44
Allowable Charge, 45
Allowed Amount, 1, 15, 19, 22, 36, 44, 49, 50, 52
Alternate Recipient, 50, 55
Ambulance, 15
Ambulatory Surgical Center, 15, 44
Ancillary Services, 2

B

Benefit Year Deductible, 45, 54
Benefits, 1, 2, 4, 5, 6, 7, 8, 9, 11, 15, 16, 17, 20, 22, 23, 26, 28, 32,
34, 35, 36, 37, 38, 41, 42, 43, 44, 45, 46, 48, 49, 52, 53, 56
Brand Name Drug, 45, 48, 51, 53

C

Child, 26, 29, 45, 46, 49, 50, 55
Close Relative, 23, 25
COBRA, 55
Coinsurance, 1, 6, 20, 45, 55
Concurrent Care, 5, 7, 8, 45
Co-payment, 1, 6, 32, 45, 55
Corporation, 25, 35, 45, 47, 50, 51, 52, 53
Cosmetic Procedure, 22, 45
Covered Expenses, 45
Credit, 45
Creditable Coverage, 28, 29, 30, 45, 46, 47
Custodial Care, 17, 22, 25

D

Deductible, 1, 11, 15, 20, 32
Dependent, 4, 5, 6, 17, 23, 26, 27, 28, 29, 30, 31, 32, 33, 36, 37, 38,
41, 46, 49, 51, 55, 56
Dependent Child, 29, 31, 36
Dependents, 33
Detoxification, 18, 46
Durable Medical Equipment, 5, 13, 16, 46, 47

E

Effective Date, 1, 29, 32
Electronic Protected Health Information, 40
Emergency Medical Condition, 2, 6, 47
Employee, 2, 9, 10, 26, 27, 28, 29, 31, 32, 33, 36, 37, 38, 41, 43,
44, 45, 46, 47, 49, 50, 51, 55, 56
Employer, 1, 26, 28, 31, 32, 39, 40, 41, 42, 43, 46, 47, 48, 53, 55,
56
Employer Group Health Plan, 35
Employer's Group Health Plan, 33, 40, 45, 49
Enrollment Date, 30, 47, 53
Excepted Benefits, 46, 47

F

Full-time Employment, 26
Full-time Student, 2, 27

G

Generic Drug, 48, 51, 53
Genetic Information, 48, 53
Group Health Plan, 7, 10, 11, 20, 23, 28, 31, 32, 34, 38, 39, 40, 41,
42, 43, 46, 47, 48, 49, 50, 53, 55

H

Health Insurance Coverage, 28, 31, 46, 48
Health Status Related Factor, 26, 31, 48
HIPAA, 3, 48
Home Health Agency, 49
Home Health Care, 5, 13, 16, 22, 25, 48, 49
Hospice Care, 5, 13, 16, 22, 49
Hospice Care Program, 16, 22
Hospital, 2, 4, 5, 16, 17, 18, 20, 22, 24, 25, 42, 44, 47, 48, 49, 52,
54, 55

I

Illness, 2, 5, 9, 15, 16, 17, 18, 22, 23, 27, 31, 34, 48, 56
Injury, 2, 5, 9, 15, 16, 17, 18, 22, 23, 31, 34, 56
Intensive Care, 16
Intensive Care Unit, 16, 49
Investigational or Experimental Services, 8

L

Late Enrollee, 28, 29, 30, 49
Long-Term Acute Care Hospital, 49

M

Medical Child Support Order, 50
Medical Necessity, 53
Medically Necessary, 4, 15, 17, 18, 22, 23, 24, 25, 44, 45, 46, 50,
53, 55
Medicare, 22, 37, 38, 46, 48, 51
Member, 2, 35, 45, 47, 48, 49, 50, 52, 53, 54, 56
Members, 49, 53
Mental and Nervous Treatment, 4, 5, 9, 17
Mental Disorder, 17, 18, 51, 55
Midwife, 51
Milieu Therapy, 22, 51

N

Newborn, 5, 16, 17, 26, 51
Newborn Care, 16, 17, 51

O

Out-of-Pocket Maximum, 54

P

Participant, 3, 4, 9, 11, 16, 17, 18, 20, 22, 23, 25, 26, 30, 31, 34, 36, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 51, 52, 53, 55, 56
Participant Effective Date, 26, 52
Participating Provider, 45, 51
Participating Provider Agreement, 51
Pharmacy, 2, 24, 25, 52, 54
Pharmacy Benefit Manager, 25, 48, 49, 51, 53
Physician, 4, 9, 15, 16, 17, 18, 19, 20, 22, 23, 24, 25, 42, 44, 49, 50, 52, 55
Physician Services, 52
Plan, i, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 14, 15, 16, 17, 18, 19, 20, 22, 23, 24, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56
Plan Administrator, 9, 27, 29, 37, 41, 53
Plan of Benefits, 1, 2, 6, 9, 14, 15, 16, 17, 20, 22, 23, 24, 26, 27, 28, 29, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56
Plan Supervisor, 1, 2, 3, 4, 5, 6, 7, 8, 10, 16, 18, 19, 27, 37, 42, 43, 44, 47, 49, 50, 52, 54
Post-service Claim, 7, 8
Pre-Authorization, 16, 20, 22, 25, 43
Pre-Authorized, 45
Pre-existing Condition, 4, 28, 29, 30, 32, 53, 54
Pre-Existing Condition, 53
Pre-existing Condition Exclusion Period, 28, 29, 30, 53
Preferred Brand Drug, 51
Preferred Drug, 51
Preferred Provider, 1, 4, 6
Premium, 33
Prescription Drug, 48, 51, 53, 55
Prescription Drugs, 14, 16, 20, 24, 25, 49, 54
Pre-service Claim, 7, 8, 53
Primary Plan, 36, 37, 54

Probationary Period, 33
Protected Health Information, 3, 39, 40, 54
Provider, 1, 2, 3, 4, 5, 6, 7, 9, 10, 17, 20, 42, 43, 44, 49, 51, 52, 54

Q

QMCSO, 55

S

Schedule of Benefits, 4, 5, 14, 15, 16, 17, 18, 20, 22, 24, 25, 26, 36, 45, 46, 49, 53, 54, 55, 56
Second Opinion, 18, 55
Secondary Plan, 36, 37, 55
Skilled Nursing Facility, 4, 5, 16, 17, 18, 22, 25, 44, 52, 54, 55
Special Enrollment, 28, 49, 55
Substance Abuse, 4, 5, 9, 18, 26, 46, 51, 55
Surgical Services, 52

T

Totally Disabled, 56
Transplant Benefit Period, 20, 55
Transplant Lifetime Maximum, 11, 20, 56

U

Urgent Care, 3, 7, 8, 43, 56
Urgent Care Claim, 3, 7, 8, 56
USERRA, 33

W

Waiting Period, 32, 47, 56