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SUMMARY PLAN DESCRIPTION

Name of Plan:
Bedford Central School District Health Benefit Plan

Name, Address and Phone Number of Employer/Plan Sponsor:
Bedford Central School District
632 South Bedford Road
Bedford, New York 10506
(914) 241-6000

Employer Identification Number:
13-6012148

Group Number:
BE

Type of Plan:
Welfare Benefit Plan: medical, dental and prescription drug benefits

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

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:
Bedford Central School District
632 South Bedford Road
Bedford, New York 10506

Legal process may be served upon the plan administrator.

Name, Title, Address and Principal Place of Business for Plan Trustees:
Bedford Central School District
632 South Bedford Road
Bedford, New York 10506

Union Plans:
The Plan is established in accordance with a collective bargaining agreement. Employees/retirees have a right to obtain a copy of the collective bargaining agreement. A written request for such copy should be submitted to the plan administrator. The collective bargaining agreement is available for examination in the plan administrator's office.
Eligibility Requirements:

For detailed information regarding a person's eligibility to participate in the Plan, refer to the following section:

*Eligibility, Enrollment and Effective Date*

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

- Schedule of Benefits
- Termination of Coverage
- Plan Exclusions

Source of Plan Contributions:

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

Funding Method:

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

Ending Date of Plan Year:

December 31

Standards Relating to Benefits for Mothers and Newborns:

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

Preferred Provider Networks

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

Procedures for Filing Claims:

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

The designated *claims processor*:

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

Benefit Period: January 1 – December 31

NOTE: For eligible post 65 retirees, benefits will be considered at the preferred provider level of benefits.

<table>
<thead>
<tr>
<th>MEDICAL BENEFITS</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong> (per benefit period)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$0</td>
<td>$400</td>
</tr>
<tr>
<td>Family</td>
<td>$0</td>
<td>$1,375</td>
</tr>
</tbody>
</table>

Generally, you must pay all of the costs from providers up to the deductible amount before Plan begins to pay. If you have other family members in this Plan, they have to meet their own individual deductible until the overall family deductible amount has been met.

**Preferred Out-of-Pocket Expense Limit** (includes deductible, coinsurance, copays and prescription cost share)
**Nonpreferred Out-of-Pocket Expense Limit** (includes deductible and coinsurance)

Out-of-Pocket Expense Limit does share between Preferred and Nonpreferred

The out-of-pocket expense limit is the most you could pay in a year for covered services. If you have other family members in this Plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been meet.

**Out-of-Pocket Expense Limit (per benefit period)**

NOTE: The nonpreferred (medical) out-of-pocket limit does not apply toward the hospital nonpreferred out-of-pocket limit.

<table>
<thead>
<tr>
<th></th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$4,600</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Family</td>
<td>$9,200</td>
<td>$3,025</td>
</tr>
</tbody>
</table>

The Plan will pay the designated percentage of covered expenses until the out-of-pocket expense limits are reached, at which time the Plan will pay 100% of the remainder of covered expenses for the rest of the benefit period unless stated otherwise.

The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%:
- expenses not covered by the Plan
- expenses in excess of amounts covered by the Plan
- expenses in excess of customary and reasonable amount

**HOSPITAL OUT-OF-POCKET EXPENSE LIMIT**

NOTE: The nonpreferred hospital out-of-pocket limit does not apply toward the (medical) nonpreferred out-of-pocket limit.

<table>
<thead>
<tr>
<th></th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Family</td>
<td>Not Applicable</td>
<td>$1,650</td>
</tr>
</tbody>
</table>
PRESCRIPTION DRUG OUT-OF-POCKET EXPENSE LIMIT

<table>
<thead>
<tr>
<th></th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Pocket Expense Limit (per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Not Applicable</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family</td>
<td>Not Applicable</td>
<td>$4,000</td>
</tr>
<tr>
<td>Standard coinsurance paid by the Plan</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
</tbody>
</table>

Services within the network where no Preferred Provider is available 80% after Deductible

Services at a Preferred Provider facility rendered by a Nonpreferred provider when the member has no choice of provider. For example, ancillary services such as radiology, pathology, laboratory and anesthesia. 80% after Deductible

NETWORK CO-PAYMENT LIMIT

$20 per provider per type of service.

Co-payment Limit: $60 per covered person per event (all services by same provider on same day). Outpatient hospital network copayments do not apply to the network co-payment limit.

PRE-CERTIFICATION REQUIREMENTS

Inpatient Admissions (hospital, rehabilitation, skilled nursing, transplant, partial hospitalizations, behavioral medicine such as psychiatric and substance abuse)

Home Health Care (including infusions and hospice)

Failure to pre-certify will result in a $250 penalty

MANDATORY MEDICAL PROCEDURE REVIEW

Dilatation and Curettage (unrelated to Pregnancy)

Gastric Stapling/Bariatric Surgery (weight reduction surgical procedures)

Hernia Repair (laparoscopic)

MRA (magnetic resonance angiography)

MRI (magnetic resonance imaging)

Varicose Vein Surgery

Failure to comply will result in a $250 penalty

MEDICAL BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>$20 co-payment, then 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>10 visits in a calendar year</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Allergy Services</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td></td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Ambulance (Land/Air)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency</td>
<td>80% after non-network deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Non-Emergency</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>MEDICAL BENEFITS</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility</td>
<td>80% after non-network deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Applied Behavior Therapy (ABA)</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Bereavement Counseling</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Biofeedback Training</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Birthing Center</td>
<td>100%</td>
<td>80% no Deductible, subject to hospital out-of-pocket maximum</td>
</tr>
<tr>
<td>Blood <em>(Blood storage and transfusions)</em></td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>$20 co-payment, then 100%</td>
<td>$20 co-payment, then 100%</td>
</tr>
<tr>
<td>Free-standing Facility/Physician Office</td>
<td>80% after non-network deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>80% after non-network deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Maximum: 3 times per week and up to a maximum 18 consecutive weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Free-standing Facility/Physician Office</td>
<td>80% after non-network deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>80% after non-network deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>10 visits in a calendar year</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Office visits</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Spinal manipulation, adjustments and x-rays</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Maximum: $750 per Covered Person per Calendar Year combined In-and Out-of-Network.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic</td>
<td>80% after non-network deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Facility</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Physician</td>
<td>80% after non-network deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Dialysis Therapy or Treatment</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Free-standing facility/Physician Office</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>80% after non-network deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Diagnostic Services – Major (such as MRI, MRA, CT Scan, PET Scan - pre-certification required for MRIs &amp; MRAs)</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Independent/Free-standing facility/Physician Office</td>
<td>$35 co-payment, then 100%</td>
<td>80% no Deductible, subject to hospital out-of-pocket maximum</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>$20 co-payment, then 100%</td>
<td>80% no Deductible, subject to hospital out-of-pocket maximum</td>
</tr>
<tr>
<td>Professional interpretation</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>MEDICAL BENEFITS</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Diagnostic Services – Minor</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>(such as x-ray, lab)</td>
<td>$35 co-payment, then 100%</td>
<td>80% no Deductible, subject to hospital out-of-pocket maximum</td>
</tr>
<tr>
<td>Independent/Free-standing facility/</td>
<td>80% after non-network deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Machine testing, Physician Office</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Patient present</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Patient not present</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional interpretation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Emergency Services – true emergency</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Facility</td>
<td>$20 co-payment, then 100%</td>
<td>$20 co-payment, then 100%</td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Services - non-emergent</td>
<td>80% after non-network deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Facility</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Home Health Care (pre-certification</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care visits</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Home health care supplies &amp; services</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>IV therapy</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Maximum: 365 days per Spell of Illness/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury. 3 visits by a member of the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care team equals 1 benefit</td>
<td>4 hours of home health care equal 1 visit.</td>
<td></td>
</tr>
<tr>
<td>day.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Inpatient (pre-certification required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Hospital – Inpatient (pre-certification</td>
<td>100%</td>
<td>80% no Deductible, subject to hospital out-of-pocket maximum</td>
</tr>
<tr>
<td>required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital – Outpatient Facility</td>
<td>$35 co-payment, then 100%</td>
<td>80% no Deductible, subject to hospital out-of-pocket maximum</td>
</tr>
<tr>
<td>Infertility Services</td>
<td>Pay as service rendered</td>
<td>Pay as service rendered</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Free-standing Facility/Physician Office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>80% after non-network deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Injectables (See Allergy Services for</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>allergy shots)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEDICAL BENEFITS</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Mental and Nervous Disorders and Substance Abuse</strong></td>
<td>100%</td>
<td>80% no Deductible, subject to hospital out-of-pocket maximum</td>
</tr>
<tr>
<td>Inpatient <em>(pre-certification required)</em></td>
<td>$20 co-payment, then 100% after Deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Outpatient visit</td>
<td></td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Outpatient other services</td>
<td></td>
<td>100% after Deductible</td>
</tr>
<tr>
<td><strong>Therapy Services</strong> (Physical, speech, occupational, etc.)</td>
<td></td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>NOTE: Network co-payment limited to $60 per individual, per event (all services by same provider on same day).</td>
<td></td>
<td>80% no Deductible, subject to hospital out-of-pocket maximum</td>
</tr>
<tr>
<td><strong>Occupational/Physical Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free standing facility/ Physician’s office</td>
<td>$20 co-payment/visit</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>Outpatient hospital</strong> <em>(therapy that starts within 6 months and is rendered within 365 days after related surgery or after discharge from related inpatient hospitalization)</em></td>
<td>$35 co-payment/visit</td>
<td>80% no Deductible, subject to hospital out-of-pocket maximum</td>
</tr>
<tr>
<td>Other medically necessary therapy</td>
<td>80% after Deductible *</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>Speech Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free standing facility/ Physician’s office</td>
<td>$20 co-payment/visit</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>Outpatient hospital</strong></td>
<td>80% after Deductible *</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>* Non-Network deductible applies</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office Visit &amp; Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit - physician <em>(includes nurse practitioners and physician assistants)</em></td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Surgery</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>Orthotics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td></td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>Podiatry Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay as service rendered</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pregnancy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial pre-natal visit and urinalysis</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Subsequent routine pre-natal visits</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Pre and post-natal care</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Delivery</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
</tbody>
</table>
### MEDICAL BENEFITS

<table>
<thead>
<tr>
<th>MEDICAL BENEFITS</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Includes all evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). Unless specifically listed below, for additional information visit: <a href="http://www.uspreventiveservicestaskforce.org">www.uspreventiveservicestaskforce.org</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone Mineral Density Measurements and Tests</td>
<td>100%</td>
<td>80% no Deductible</td>
</tr>
<tr>
<td>BRCA Genetic Counseling (related to genetic screening for breast and ovarian cancer)</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>100%</td>
<td>80% no Deductible</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV) DNA Testing</td>
<td>100%</td>
<td>80% no Deductible</td>
</tr>
<tr>
<td>Mammography, Routine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Outpatient hospital</td>
<td>100%</td>
<td>$25 co-payment, then 100%</td>
</tr>
<tr>
<td>- Other providers</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Prenatal Screening</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Well Adult Care (age 18 and older)</td>
<td>100%</td>
<td>80% no Deductible</td>
</tr>
<tr>
<td>MEDICAL BENEFITS</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Women’s Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As required by the Patient Protection and Affordable Care Act:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening for gestational diabetes in a pregnant woman;</td>
<td>100%</td>
<td>80% no Deductible</td>
</tr>
<tr>
<td>Human papillomavirus DNA testing every three (3) years for women age thirty (30) and above;</td>
<td>100%</td>
<td>80% no Deductible</td>
</tr>
<tr>
<td>Annual counseling for sexually transmitted infections for a sexually active woman;</td>
<td>100%</td>
<td>80% no Deductible</td>
</tr>
<tr>
<td>Annual counseling and screening for human immune-deficiency virus for a sexually active woman;</td>
<td>100%</td>
<td>80% no Deductible</td>
</tr>
<tr>
<td>FDA approved contraceptive methods;</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Sterilization procedures, patient education and counseling for women with reproductive capacity;</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Breastfeeding support, supplies and counseling in conjunction with each birth, including the cost of purchasing or renting breastfeeding equipment; and</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Annual screening and counseling for interpersonal and domestic violence.</td>
<td>100%</td>
<td>80% no Deductible</td>
</tr>
<tr>
<td><strong>Private Duty Nursing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient only - Limited to $30 per hour for an Approved Plan of Care. Charges more than $30 per hour are not covered.</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>Prostate Examinations</strong></td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Prostheses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>Pulmonary Rehabilitation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free-standing Facility/Physician Office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td></td>
<td>80% after non-network deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>Radiation Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free-standing Facility/Physician Office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>Respiratory Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free-standing Facility/Physician Office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td></td>
<td>80% after non-network deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>Second Surgical Opinion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mandatory</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Voluntary</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td><strong>Skilled Nursing</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>MEDICAL BENEFITS</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>MEDICAL BENEFITS</strong></td>
<td><strong>PREFERRED PROVIDER</strong></td>
<td><strong>NONPREFERRED PROVIDER</strong></td>
</tr>
<tr>
<td>(pre-certification required)</td>
<td>Maximum: 150 Days per Spell of Illness/Injury. Once the 150 per Spell of Illness/Injury days is exhausted, the skilled nursing benefit days will count toward the 365 per Spell of Illness/Injury Hospital - Inpatient days.</td>
<td></td>
</tr>
<tr>
<td>Surgery Surgeon, Assistant Surgeon, Anesthesiologist</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Temporomandibular Joint Syndrome (TMJ) Treatment</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Telemedicine Visit (from Teladoc)</td>
<td></td>
<td>$20 Copay</td>
</tr>
<tr>
<td>Transplants (Organ or Tissue) (pre-certification required) Facility</td>
<td>Pay as service rendered</td>
<td>Pay as service rendered</td>
</tr>
<tr>
<td>Physician Travel/Meals Lodging</td>
<td>Pay as service rendered Not covered</td>
<td>Pay as service rendered Not covered</td>
</tr>
<tr>
<td>Ultraviolet/PUVA Therapy</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Urgent Care Facility/Physician/All other services</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Urgent Care - Retail Clinic</td>
<td>$20 co-payment, then 100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Vision – Routine Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Weight Loss Services Surgical treatment (pre-certification required) Non-surgical treatment and programs</td>
<td>Pay as service rendered</td>
<td>Pay as service rendered</td>
</tr>
<tr>
<td></td>
<td>Pay as service rendered</td>
<td>Pay as service rendered</td>
</tr>
<tr>
<td>Maximum: Bariatric Surgery is limited to once per covered person in a lifetime.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wigs after Cancer Therapy</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Maximum: $250 in a lifetime</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other Covered Expenses</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
</tbody>
</table>
### Out-of-Pocket Expense Limit (per calendar year)

<table>
<thead>
<tr>
<th>Category</th>
<th>Preferred Provider</th>
<th>NonPreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Not Applicable</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family</td>
<td>Not Applicable</td>
<td>$4,000</td>
</tr>
</tbody>
</table>

### Prescription Drug Benefits

<table>
<thead>
<tr>
<th>Prescriptions</th>
<th>Preferred Provider</th>
<th>NonPreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail Pharmacy</strong> (34-day supply or 100 unit doses, whichever is greater)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10 Copay</td>
<td>$10 Copay</td>
</tr>
<tr>
<td>Preferred Brand Name</td>
<td>$30 Copay</td>
<td>$30 Copay</td>
</tr>
<tr>
<td>Non-Preferred Brand Name</td>
<td>$30 Copay</td>
<td>$30 Copay</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>Same as above</td>
<td>Same as above</td>
</tr>
<tr>
<td>Specified Drugs - Coumadin, Dilantin,</td>
<td>$15 Copay</td>
<td>$15 Copay</td>
</tr>
<tr>
<td>Lanoxin, Levothroid, Synthroid, Premarin,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slo-bid, Tegretol and Theo-Dur</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mail Order Pharmacy</strong> (90-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$13 Copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Preferred Brand Name</td>
<td>$35 Copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Non-Preferred Brand Name</td>
<td>$35 Copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specified Drugs - Coumadin, Dilantin,</td>
<td>$20 Copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Lanoxin, Levothroid, Synthroid, Premarin,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slo-bid, Tegretol and Theo-Dur</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the covered person selects a brand drug when a generic equivalent is available, the covered person is responsible for the generic copay plus the cost difference between the generic and brand equivalent. If the physician indicates no substitutions, the covered person is only responsible for the brand co-pay.
# DENTAL BENEFITS

<table>
<thead>
<tr>
<th>Deductible (per benefit period)</th>
<th>Individual</th>
<th>$25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>$75</td>
<td></td>
</tr>
</tbody>
</table>

**Maximum Benefit**

Class I, II, III Combined (per person per Benefit Period)

<table>
<thead>
<tr>
<th>Class IV - Orthodontic Services</th>
<th>$2,000 per individual per benefit period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,000 per lifetime</td>
</tr>
</tbody>
</table>

**NOTE:** Two (2) payments for orthodontic services of up to $500 in a calendar year during each of two (2) separate calendar years of the Covered Person’s lifetime (maximum of $1,000). Orthodontic benefits also count toward the calendar year maximum. No more than $2,000 will be paid by the Plan for any combination of orthodontic or non-orthodontic expenses incurred in the same calendar year for each Covered Person.

## Class I – Diagnostic & Preventive Dental Services

- Exams – 2 every calendar year
- Prophylaxis – 2 every calendar year
- Full Mouth X-ray - 1 every 36 months
- Bitewings – 2 every calendar year
- Panoramic – 1 every 36 months, with or without full mouth x-rays/complete series
- Periapical X-rays
- Fluoride - under age 19 - 1 every calendar year
- Space Maintainers – 1 every 3 consecutive years
- Sealants - under age 15 - 1 per tooth every 3 consecutive years

80% after Deductible

## Class II – Basic Dental Services

- Emergency exams/Palliative Treatment
- Tests and Laboratory examinations
- Prescribed medications
- Basic Restorations/Fillings (resin, silicate, plastic, amalgam or composite fillings)
- Crown and prosthetic repairs
- Endodontics
- Periodontics
- Oral surgery/Exactions – Simple, surgical, impacted, cyst/tumor removal
- General Anesthetic
- Prosthetic repairs
- Consultations

80% after Deductible

## Class III – Major Dental Services

- Major Restorations/Fillings (Precious metal fillings)
- Crowns
- Inlays/Onlays
- Bridgework
- Partial/Full Dentures
- Reline/Rebase Dentures

There is a 5 year replacement rule.

60% after Deductible

## Class IV – Orthodontic Services

60% after Deductible
PREFERRED PROVIDER OR NONPREFERRED PROVIDER

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

PREFERRED PROVIDER

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

NONPREFERRED PROVIDER

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

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

REFERRALS

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

EXCEPTIONS

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

1. Emergency services rendered at a nonpreferred provider facility or at a preferred provider facility by a nonpreferred provider. If the covered person is admitted to the hospital on an emergency basis, covered expenses shall be payable at the preferred provider level. The in-network benefit will continue for the duration of the hospitalization.

2. Nonpreferred anesthesiologist when the facility where such services are rendered is a preferred provider.

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

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

6. While the covered person is confined to a preferred provider hospital, the preferred provider physician requests a consultation from a nonpreferred provider, or a newborn visit is performed by a nonpreferred provider.

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

8. Treatment rendered at a facility of the uniformed services.

9. Transportation by a nonpreferred provider ambulance for a condition that meets the definition of emergency.

10. Lactation counseling providers.
MEDICAL EXPENSE BENEFIT

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

COPAY

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

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

DEDUCTIBLES

Individual Deductible

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

Family Deductible

If there are other family members in this Plan, they have to meet their own individual deductible until the overall family deductible amount has been met.

Common Accident

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

COINSURANCE

The Plan pays a specified percentage of covered expenses as the customary and reasonable amount for nonpreferred providers, or the percentage of the negotiated rate for preferred providers. That percentage is specified on the Schedule of Benefits. For nonpreferred providers, the covered person is responsible for the difference between the percentage the Plan paid and one hundred percent (100%) of the billed amount.

OUT-OF-POCKET EXPENSE LIMIT

After the covered person has incurred an amount equal to the preferred provider out-of-pocket expense limit listed on the Schedule of Benefits for covered expenses, the Plan will begin to pay one hundred percent (100%) of covered expenses for the remainder of the calendar year.
If there are other family members in this Plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been meet.

Out-of-Pocket Expense Limit Exclusions

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

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

MAXIMUM BENEFIT

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

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

HOSPITAL/AMBULATORY SURGICAL FACILITY

Covered expenses shall include:

1. Room and board for treatment in a hospital, including intensive care units, cardiac care units and similar medically necessary accommodations. Covered expenses for room and board shall be limited to the hospital's semiprivate rate. Covered expenses for intensive care or cardiac care units shall be the customary and reasonable amount for nonpreferred providers and the percentage of the negotiated rate for preferred providers. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the covered person.

2. Miscellaneous hospital services, supplies, and treatments including, but not limited to:
   a. Admission fees, and other fees assessed by the hospital for rendering services, supplies and treatments;
   b. Use of operating, treatment or delivery rooms;
   c. Anesthesia, anesthesia supplies and its administration by an employee of the hospital;
   d. Medical and surgical dressings and supplies, casts and splints;
   e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
   f. Drugs and medicines (except drugs not used or consumed in the hospital);
   g. X-ray and diagnostic laboratory procedures and services;
   h. Oxygen and other gas therapy and the administration thereof;
   i. Therapy services.

3. Services, supplies and treatments described above furnished by an ambulatory surgical facility, including follow-up care provided within seventy-two (72) hours of a procedure.
4. Charges for pre-admission testing (x-rays and lab tests) performed prior to a hospital admission which are related to the condition which is necessitating the confinement. Such tests shall be payable even if they result in additional medical treatment prior to confinement or if they show that hospital confinement is not medically necessary. Such tests shall not be payable if the same tests are performed again after the covered person has been admitted.

**AMBULANCE SERVICES**

*Covered expenses* shall include:

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

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

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

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

**EMERGENCY SERVICES/EMERGENCY ROOM SERVICES**

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

Emergency room treatment for conditions that do not meet the definition of emergency will be considered non-emergency use of the emergency room and will be subject to the benefits as shown on the Schedule of Benefits.

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

**URGENT CARE CENTER**

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

**ACCIDENT EXPENSE BENEFIT**

Initial treatment and follow-up care within ninety (90) days of an injury will be payable, subject to any applicable maximum benefit, as specified in the Schedule of Benefits.

**PHYSICIAN SERVICES AND PROFESSIONAL PROVIDER SERVICES**

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

1. Medical treatment, services and supplies including, but not limited to: office visits, inpatient visits, home visits.
2. Surgical treatment. Separate payment will not be made for inpatient pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

For related operations or procedures performed through the same incision or in the same operative field, covered expenses shall include the surgical allowance for the highest paying procedure, plus fifty percent (50%) of the surgical allowance for each additional procedure.

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

3. Surgical assistance provided by a physician or professional provider if it is determined that the condition of the covered person or the type of surgical procedure requires such assistance. Covered expenses for the services of an assistant surgeon are limited to twenty percent (20%) of the surgical allowance.

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

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

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

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

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

SECOND SURGICAL OPINION

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

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

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

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

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

DIAGNOSTIC SERVICES AND SUPPLIES

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


**TRANSPLANT**

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

1. When the recipient is covered under the *Plan*, the *Plan* will pay the recipient's *covered expenses* related to the transplant.

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

3. Expenses *incurred* by the donor who is not ordinarily covered under the *Plan* according to eligibility requirements will be *covered expenses* to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under the *Plan*. The donor’s expenses shall be applied to the recipient's *maximum benefit*. In no event will benefits be payable in excess of the *maximum benefit*.

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

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

*Centers of Medical Excellence Program*

**Types of Providers**

The *claims administrator* is providing access to the following separate *Centers of Medical Excellence (CME)* networks. The facilities included in each of these CME networks are selected to provide the following specified medical services:

**Transplant Facilities**. Transplant facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Subject to any applicable co-payments or deductibles, CME have agreed to a rate they will accept as payment in full for covered services.

**PREGNANCY**

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

Complications from an abortion shall be a *covered expense* whether or not the abortion is a *covered expense*.

**BIRTHING CENTER**

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

*Covered expenses* shall include elective surgical sterilization procedures for the covered male *employee/retiree* or covered male spouse. Reversal of surgical sterilization is not a *covered expense*. *Covered expenses* for elective surgical sterilization procedures for women shall be considered under the subsection, *Women’s Preventive Services*.

**INFERTILITY SERVICES**

Coverage is limited to AI (artificial insemination), IUI (intra-uterine insemination) or IVF (in-vitro fertilization) when needed due to medical condition of the patient or due to abnormal male (spouse of the patient) factors contributing to infertility. Coverage is available up to a maximum of six (6) ovulatory cycles per course of treatment when rendered within two (2) consecutive years. To obtain coverage approval for a course of AI, IUI or IVF, the *Physician* must provide a statement of medical necessity including details on condition, medical history, previous infertility or AI/IUI/IVF treatment and proposed treatment plan. The *Claims processor* will advise whether coverage is available according to *Plan* limitations and exclusions. Any combination of AI/IUI/IVF will only be reimbursed up to the value of six (6) cycles of AI/IUI in two (2) years. Any amounts exceeding this value will be the responsibility of the member. Benefits are limited to the following:

1. Initial course of AI/IUI/IVF up to six (6) ovulatory cycles within two (2) years.

2. If the treatment course is not successful (does not result in confirmed pregnancy), benefits will be considered exhausted. Coverage will not be available for subsequent AI/IUI/IVF expenses.

3. If the initial course of treatment is successful (results in confirmed pregnancy) within six (6) cycles, coverage becomes available for a second course of AI/IUI/IVF treatment. Benefits will be considered exhausted after the second course of treatment. Coverage will not be available for subsequent AI/IUI/IVF treatment.

4. Exhausted coverage or benefits is for a lifetime.

Benefits for the resulting pregnancy will be considered separately as maternity care. However, expenses related to surrogate maternity care are not covered. Expenses related to the procurement of sperm donated by the patient’s spouse are covered only when part of an approved course of treatment for AI/IUI/IVF. If services are not part of an approved course of treatment, the procurement expenses are not covered, whatever the reason. Coverage is not provided for infertility or artificial conception services and supplies related to surrogate pregnancies. Expenses related to freezing and storage of sperm are not covered, whatever the reason. Reproductive coverage is limited to AI/IUI/IVF shown above. **Coverage is not provided for other care such as fertility or Infertility care or other treatment rendered for the purpose of reproduction.** However, surgical or medical procedures directed at treatment of an identifiable organic disease or organic disorder will be considered the same as any other Illness.

**CONTRACEPTIVES**

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

**WELL NEWBORN CARE**

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

Such care shall include, but is not limited to:

1. *Physician* services

2. *Hospital* services
3. Circumcision

**ROUTINE PREVENTIVE CARE/WELLNESS BENEFITS**

Routine Preventive Care/Wellness Benefits shall include:

1. Evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Annual routine mammograms for women as recommended by the United States Preventive Services Task Force (USPSTF).
3. Colonoscopies, including pre-procedure consultation, bowel preparation kits and pathology exam, for adults.
4. Routine immunizations, as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention.
5. Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration for infants, children, adolescents and adult women, unless included in the USPSTF recommendations.
6. Screening for tobacco use and two (2) tobacco cessation attempts per year and tobacco cessation medications for a ninety (90) day treatment regimen when prescribed by a physician.

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

**WOMEN’S PREVENTIVE SERVICES**

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

1. Annual well-woman office visits to obtain preventive care;
2. Screening for gestational diabetes in a pregnant woman;
3. Human papillomavirus (HPV) DNA testing no more frequently than every three (3) years for a woman age thirty (30) and above;
4. Annual counseling for sexually transmitted infections for a sexually active woman;
5. Annual counseling and screening for human immune deficiency virus for a sexually active woman;
6. FDA approved contraceptive methods, sterilization procedures and patient education and counseling for a woman with reproductive capacity;
7. Breastfeeding support, supplies and counseling, to include the cost of rental or purchase, whichever is less costly, of breastfeeding equipment; and
8. Annual screening and counseling for interpersonal and domestic violence.
9. Genetic counseling for women identified to be at higher risk of having a potentially harmful gene mutation, and, if indicated, BRCA testing for harmful BRCA mutations.

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

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

*Covered expenses* shall include one (1) routine prostate examination per calendar year, for men age forty (40) and over.

**THERAPY SERVICES**

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

*Covered expenses* shall include:

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

**EXTENDED CARE FACILITY**

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

*Covered expenses* shall include:

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

**HOME HEALTH CARE**

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

1. Part-time or intermittent nursing care by a *nurse*;
2. Physical, respiratory, occupational or speech therapy;
3. Part-time or intermittent *home health aide services* for a *covered person* who is receiving covered nursing or therapy services;
4. Medical social service consultations;
5. Nutritional guidance by a registered dietitian and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be *medically necessary*. 
A visit by a member of a home health care team and four (4) hours of home health aide service will each be considered one (1) home health care visit.

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

**HOSPICE CARE**

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

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

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

**Covered expenses** shall include:

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

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

**DURABLE MEDICAL EQUIPMENT**

Rental or purchase, whichever is less costly (except as noted below for oxygen concentrators), of medically necessary durable medical equipment which is prescribed by a physician and required for therapeutic use by the covered person shall be a covered expense.

A charge for the purchase or rental of durable medical equipment is considered incurred on the date the equipment is received/delivered. Durable medical equipment that is received/delivered after the termination date of a covered person’s coverage under the Plan is not covered. Repair or replacement of purchased durable medical equipment which is medically necessary due to normal use or a physiological change in the patient’s condition will be considered a covered expense.
Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the covered person's condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the covered person's medical needs.

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

Covered expenses for the rental or purchase, whichever is less costly, of breastfeeding equipment shall be considered under the subsection, Women's Preventive Services.

**PROSTHESSES**

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

**ORTHOTICS**

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

**DENTAL SERVICES**

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

Covered expenses shall include charges for oral surgery such as closed or open reduction of fractures or dislocations of the jaw, and other incision or excision procedures performed on the gums and tissues of the mouth when not performed in conjunction with the extraction of teeth.

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

**SPECIAL EQUIPMENT AND SUPPLIES**

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

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

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

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

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

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

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

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

1. reconstruction of a surgically removed breast, including nipple and areola reconstruction and repigmentation; and

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

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

MENTAL & NERVOUS DISORDERS

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

Covered expenses shall include:

1. Inpatient hospital confinement;

2. Individual psychotherapy;

3. Group psychotherapy;

4. Psychological testing;

5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional provider.

CHEMICAL DEPENDENCY CARE

The Plan will pay for medically necessary covered expenses for the inpatient and outpatient treatment of chemical dependence in a hospital or treatment center by a physician or professional provider.
ROUTINE PATIENT COSTS FOR APPROVED CLINICAL TRIALS

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

1. An investigational item, device or service;
2. An item or service provided solely to satisfy data collection and analysis needs, which are not used in the direct clinical management of the patient; or,
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

1. The referring health care professional has concluded that the covered person’s participation in such trial would be appropriate; or,
2. The covered person provides medical and scientific information establishing that the covered person’s participation in such trial would be appropriate.

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

OFF-LABEL DRUG USE

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

PHASE III ONCOLOGY CLINICAL TRIALS

Covered expenses shall include charges for a drug, device, supply, treatment, procedure or service that is part of a scientific study of cancer therapy in a Phase III clinical trial sponsored by the National Cancer Institute or institution of similar stature subject to any maximum benefit shown on the Schedule of Benefits. Trials must have Institutional Review Board (IRB) approval by a qualified IRB. Charges that are not covered include:

1. Costs for services that are not primarily for the care of the patient (such as lab services performed solely to collect data for the trial).
2. Costs for services provided in a clinical trial that are funded by another source.

PODIATRY SERVICES

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

*Covered expenses* include initial consultation, x-rays and treatment (but not maintenance care).

PATIENT EDUCATION

*Covered expenses* shall include *medically necessary* patient education programs including, but not limited to diabetic education and ostomy care. *Covered expenses* for patient education for contraception or lactation training shall be considered under the subsection, *Women's Preventive Services*.

SURCHARGES

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

OUTPATIENT CARDIAC /PULMONARY REHABILITATION PROGRAMS

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

SURGICAL TREATMENT OF MORBID OBESITY

*Covered expenses* shall include charges for surgical treatment of *morbid obesity* for *covered persons* with health problems that are aggravated by or related to the *morbid obesity*, including, but not limited to gastric by-pass, gastric stapling or gastric balloon when determined to be *medically necessary*.

NON-SURGICAL TREATMENT OF MORBID OBESITY

*Covered expenses* shall include charges for weight-loss programs that are administered and supervised by a *hospital* or *physician’s* clinic to treat a medical condition by a decrease in the patient's weight. This program must not be a weight reduction program, but a program designed to treat health problems associated with high-risk *morbid obesity*. These health conditions may include hypertension, diabetes, cardiovascular disease, sleep apnea and degenerative joint disease. The patient must have demonstrated unsuccessful results in a weight loss program. Coverage is limited to *medically necessary* charges for treatment of *morbid obesity*.

SLEEP DISORDERS

*Covered expenses* shall include charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.
The Plan will not provide benefits for any of the items listed in this section, regardless of medical necessity or recommendation of a physician or professional provider, unless otherwise stated.

Abortion - Charges for services provided to a covered person for an elective or voluntary abortion. However, complications from such procedure shall be a covered expense for a covered female employee/retiree or the covered female spouse of an employee/retiree.

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

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

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

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

Counseling - Charges for marriage, career or legal counseling.

Crime - Charges in connection with any illness or injury of the covered person resulting from or occurring during the plan administrator's commission or attempted commission of a criminal battery or felony. Claims shall be denied if the plan administrator has reason to believe, based on objective evidence such as police reports or medical records, that a criminal battery or felony was committed by the covered person. This exclusion will not apply to an illness and/or injury sustained due to a medical condition (physical or mental) or domestic violence.

Custodial Care - Charges for custodial care, domiciliary care or rest cures.

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

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

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

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

Effective Date - Charges for services rendered and/or supplies received prior to the effective date or after the termination date of a person's coverage, except as specifically provided herein.

Employment - Charges for employment physicals, or any related charges, such as premarital lab work.
Exercise Programs - Charges for exercise programs for treatment of any condition, except as specified herein.

Experimental/Investigational - Charges for drugs, devices, supplies, treatments, procedures or services that are considered experimental/investigational by the Plan. The Plan will consider a drug, device, supply, treatment, procedure or service to be “experimental” or “investigational”:
   a. if, in the case of a device or supply, the device or supply cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device or supply is furnished; or
   b. if the drug, device, supply, treatment, procedure or service, or the patient’s informed consent document utilized with respect to the drug, device, supply, treatment, procedure or service was reviewed and approved by the treating facility’s institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
   c. if the plan sponsor (or its designee) determines in its sole discretion that the drug, device, supply, treatment, procedure or service is the subject of on-going Phase I or Phase II clinical trials; is the research, experimental, study or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine maximum tolerated dose, toxicity, safety or efficacy, however, a drug, device, supply, treatment, procedure or service that meets the standards set in the section Medical Expense Benefit Phase III Oncology Clinical Trials or Off-Label Drug Use will not be deemed experimental or investigational solely by reason of this subparagraph; or
   d. if the plan sponsor (or its designee) determines in its sole discretion based on documentation in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature that the prevailing opinion among experts regarding the drug, device, supply, treatment, procedure or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy.

Foot Care - Except as medically necessary for the treatment of metabolic or peripheral-vascular illness, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

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

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

Hair - Charges for wigs, artificial hairpieces, artificial hair transplants, or any drug prescription or otherwise -used to eliminate baldness or stimulate hair growth, except as specified herein.

Hearing - Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid; bone-anchored hearing aid, auditory brainstem implant, or any other surgically implantable device to correct hearing loss, or surgery to implant such a device. FDA cochlear implants are covered.

Holistic Medicines - Charges for holistic medicines or providers of naturopathy.

Hypnosis - Charges for expenses related to hypnosis.

Infertility - Charges for services, supplies or treatment related to the treatment of infertility and artificial reproductive procedures, including, but not limited to: surrogate mother, and fertility drugs when used for treatment of infertility, embryo implantation, or gamete intrafallopian transfer (GIFT). Coverage is limited to AI (artificial insemination), IUI (intra-uterine insemination) or IVF (in-vitro fertilization) when needed due to medical condition of the patient or due to abnormal male (spouse of the patient) factors contributing to infertility.

Law - To the extent that payment under the Plan is prohibited by any law of any jurisdiction in which the covered person resides at the time the expense is incurred.
License - Charges for services, supplies or treatment rendered by physicians or professional providers beyond the scope of their license; for any treatment, confinement or service which is not recommended by or performed by an appropriate professional provider.

Massage - Charges for massage therapy, sex therapy, or recreational therapy.

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

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

Orthotics - Orthotics or other foot devices and supports used for foot disorders, except when needed after an open cutting surgical procedure.

Orthopedic Shoes - Charges for orthopedic shoes or shoe inserts.

Overlapping Coverage - Benefits which are payable under any one section of the Plan shall not be payable as a benefit under any other section of the Plan. For example, if a benefit is eligible under both the Medical Expense Benefit section and the Dental Expense Benefit section, and is paid under the Medical Expense Benefit, the remaining balance will not be paid under the Dental Expense Benefit.

Primary Coverage - If the primary plan has a restricted list of healthcare providers and the covered person chooses not to use a provider from the primary plan's restricted list, this Plan will not pay for any charges disallowed by the primary plan due to the use of such provider, if shown on the primary carrier's explanation of benefits. This Plan will not pay for any charge which has been refused by another plan covering the covered person as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.

Private Duty Nursing - Charges for inpatient private duty nursing.

Relatives - Charges for services, supplies or treatment rendered by any individual who is a close relative of the covered person or who resides in the same household as the covered person.

Reversal of Sterilization - Charges for services, supplies or treatment for the reversal of surgical sterilization procedures.

School, Sports - Charges for sports physicals, or preschool or school examinations.

Sexual Dysfunction - Charges for treatment or surgery for sexual dysfunction or inadequacies unless related to injury or organic illness.

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

Structural Changes - Charges for structural changes to a house or vehicle.

Temporomandibular Joint Dysfunction (TMJ) - Charges for treatment of temporomandibular joint dysfunction (TMJ) or myofascial pain syndrome.

Third Party Liability - Charges for illnesses or injuries suffered by a covered person due to the action or inaction of any party if the covered person fails to provide information as specified in the section, Subrogation/Reimbursement.
Timely Filing - Claims not submitted within the Plan's filing limit deadlines as specified in the section, Claim Filing Procedure.

Transplants – Charges for transportation, lodging and meals.

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

Travel, Immunizations - Charges for immunizations required for travel.

Vision - Charges for routine vision examinations and eye refractions; eyeglasses or contact lenses; dispensing optician's services, except as specified herein. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.

Vitamins/Supplements - Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.

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

Weight Reduction Programs - Charges for non-surgical services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and hospital confinements for weight reduction programs, except as specifically provided herein or as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

Workers' Compensation - Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the covered person fails to claim rights to such benefits or fails to enroll or purchase such coverage. Charges in connection with any illness or injury arising out of or in the course of any employment intended for wage or profit, including self-employment.
PRESCRIPTION DRUG PROGRAM

**PHARMACY OPTION**

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

**PHARMACY OPTION COPAY OR COINSURANCE**

The *copay* or *coinsurance* is applied to each covered pharmacy drug charge and is shown on the *Schedule of Benefits*. The *copay* or *coinsurance* amount is not a *covered expense* under the *Medical Expense Benefit*. Any one prescription is limited to the greater of thirty-four (30) day supply or a one hundred (100) unit dose. Maintenance drugs (drugs which are prescribed for long-term usage) may be dispensed in a ninety (90) day supply.

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

If the *covered person* purchases a brand name drug when the *physician* has indicated a *generic drug* can be dispensed, the *covered person* will be required to pay the difference between the *generic drug* and the brand name requested, plus the usual *copay* or *coinsurance*. The *covered person* may appeal the adverse benefit determination. This difference between the cost of the brand name drug and the *generic drug* shall not accumulate toward the out-of-pocket limit.

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

Drugs purchased from a *nonparticipating pharmacy* are not covered.

**MAIL ORDER OPTION**

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

**MAIL ORDER OPTION COPAY OR COINSURANCE**

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

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

Drugs purchased from a *nonparticipating pharmacy* are not covered.

**COVERED PRESCRIPTION DRUGS**

1. Drugs prescribed by a *physician* that require a prescription either by federal or state law except drugs excluded by the *Plan*.

2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Insulin, insulin needles and syringes and diabetic supplies.
4. Oral contraceptives, regardless of the reason prescribed.
5. Oral drugs used in the treatment of erectile dysfunction (with prior authorization).
6. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a qualified prescriber.
7. Routine preventive drugs as required by the Affordable Care Act.
8. Acne products (including Tretinoins).

**LIMITS TO THIS BENEFIT**

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

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

**EXPENSES NOT COVERED**

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin or routine preventive drugs as required by the Affordable Care Act.
2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.
3. Immunization agents or biological sera, blood or blood plasma.
4. A drug or medicine labeled: “Caution - limited by federal law to investigational use.”
5. Experimental drugs and medicines, even though a charge is made to the covered person.
6. Any charge for the administration of a covered prescription drug.
7. Any drug or medicine that is consumed or administered at the place where it is dispensed.
8. A drug or medicine that is to be taken by the covered person, in whole or in part, while hospital confined. This includes being confined in any institution that has a facility for dispensing drugs.
9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.
10. A charge for prescription drugs for smoking cessation purposes, including smoking deterrent patches, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.
12. A charge for infertility medication without prior authorization.
15. A charge for minerals.

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

18. A charge for growth hormones.

19. A charge for weight loss drugs.

20. A charge for Levonorgestrel (Norplant implants).


22. A charge for drugs used in the treatment of erectile dysfunction, except oral drugs with prior authorization.

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

24. A charge for over the counter products.

**NOTICE OF AUTHORIZED REPRESENTATIVE**

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

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

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

The following describes the review process and rights of the covered person for a full and fair review:

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

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

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

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

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

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

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

**EXTERNAL APPEAL**

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

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

If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. (Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.)

**RIGHT TO EXTERNAL APPEAL**

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

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

**NOTICE OF RIGHT TO EXTERNAL APPEAL**

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

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

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 866-444-3272, if the request is complete but not eligible for external review.

2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the covered person to perfect the external review request by the later of the following:
   a. The four (4) month filing period; or
   b. Within the forty-eight (48) hour time period following the covered person’s receipt of notification.
INDEPENDENT REVIEW ORGANIZATION

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and shall be assigned to conduct the external review. The assigned IRO will timely notify the covered person in writing of the request’s eligibility and acceptance for external review.

NOTICE OF EXTERNAL REVIEW DETERMINATION

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

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

EXPEDITED EXTERNAL REVIEW

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

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

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

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

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

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

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

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

DEDUCTIBLE

Individual Deductible

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

Family Deductible

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

Common Accident

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

COINSURANCE

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

MAXIMUM BENEFIT

The maximum calendar year benefit payable on behalf of a covered person for covered dental expense is stated on the Schedule of Benefits. If the covered person’s coverage under the Plan terminates and he subsequently returns to coverage under the Plan during the calendar year, the Essential Health Benefit maximum benefit for a covered person under age eighteen (18) and the non-Essential Health Benefit maximum benefit for a covered person age eighteen (18) and older will be calculated on the sum of benefits paid by the Plan.

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

ALTERNATIVE TREATMENT

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

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

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

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

**COVERED DENTAL EXPENSES**

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

*Class I  Diagnostic and Preventive Dental Services*

1. Routine oral examination: Initial or periodic, limited to twice per calendar year.
2. Prophylaxis: Scaling and cleaning of teeth, limited to twice per calendar year.
3. Dental x-rays as follows:
   a. Supplementary bite-wing x-rays, limited to twice per calendar year.
   b. Panorex and/or full mouth series, limited to one (1) each every thirty-six (36) months.
   c. Other dental x-rays necessary for the diagnosis of a specific condition requiring treatment.
4. Topical application of fluoride for dependent children through the age of eighteen (18), limited to one (1) treatment per calendar year.
5. Space maintainers, fixed appliance (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments. This does not include space maintainers used in orthodontics to create a space between teeth.
6. Topical application of sealant to permanent posterior teeth, for dependent children through the age of fourteen (14), limited to one (1) treatment per tooth every three (3) consecutive years.

*Class II  Basic Dental Services*

1. *Emergency* palliative treatment primarily for relief of dental pain, not cure. Only paid as a separate benefit when no other treatment (except x-rays) is rendered during the visit.
2. **Tests and Laboratory Examinations.** Benefits are provided for the following tests and laboratory examinations related to covered dental treatment. Routine or preventive tests are not covered. Sometimes, a service could be considered an integral part of another service or case fee procedure. In such cases, benefits will be limited to the allowance for the major service or procedure. Separate benefits will not be available if billed separately from the major procedure.
3. **Basic Restorative Services.** The following services are covered for restoration of tooth damage due to dental decay or injury only. Services must be considered appropriate and usual for the dental conditions. Services primarily for cosmetic or aesthetic reasons are not covered. Allowance for restoration procedures includes preparation, supplies, local anesthetic and normal follow-up care. Separate charges for these inclusive services are not covered. Multiple surfaces restored on the same tooth are considered one filling. The Plan allowance will be based on the number of surfaces for each filling per each tooth.
   a. Fillings consisting of resin (silver amalgam, silicate and plastic or a composite of these materials).
   b. Sedative filling when not considered part of another procedure. Example: root canal therapy, palliative care.
   c. Core Buildup, including any pins, pin retention, cast post and core in addition to crown.
   d. Pin Retention in addition to restoration.
   e. Temporary Crown for fractured tooth.

4. **Endodontics.** Coverage includes treatment for diseases of pulp cavities inside the root of a tooth and surrounding tissues. Allowance for endodontic procedures includes preparation, supplies, local anesthetic and usual after care. Separate charges for these inclusive services are not covered.
   a. Pulp capping exclusive of final restoration.
   b. Therapeutic pulpotomy exclusive of final restoration. Not covered separately if done during root canal therapy.
   c. Root canal therapy including treatment plan, intraoperative X-rays, clinical procedures and follow up care.
   d. Periapical services including apicoectomy, retrograde filling per root, root amputation per root and reimplantation of tooth including necessary splinting.
   e. Hemisection (including any root removal), not including root canal therapy.

Bleaching of a discolored tooth is not covered whatever the reason.

5. **Periodontics.** Coverage includes treatment of periodontal and other diseases to or around the root portion of a tooth except periodontal prophylaxis. Allowance for periodontic procedures includes preparation, supplies, local anesthetic and usual after care. Separate charges for these inclusive procedures are not covered.
   a. Surgical periodontic preoperative examination.
   b. Gingival curettage when not part of tooth extraction. (Generally needed for localized sites of recalcitrant periodontitis, juvenile periodontitis, treatment of gingivitis, slight periodontitis or aesthetic purposes.) Benefits are not payable for services rendered primarily for aesthetic purposes.
   c. Mucogingival surgery.

6. **Oral Surgery.** Allowance for oral surgery includes supplies, local anesthesia and normal follow-up care. Separate charges for these inclusive services are not covered. Surgery must be due to oral or dental disease or injury. Services done for aesthetic or cosmetic purposes are not covered. Services done for orthodontic reasons are covered as orthodontic expense subject to the orthodontic benefit limitations.
   a. Simple extractions.
   b. Root removal of exposed roots when not related to extraction of teeth.
   c. Surgical extractions of erupted teeth.
   d. Surgical extraction of bony or tissue impacted teeth (partially or completely impacted).
   e. Surgical removal of residual tooth roots (cutting procedure) when not related to tooth extraction.
   f. Biopsy of oral tissue done by incisional cutting procedure. Biopsy not covered if done with another cutting procedure.
g. Surgical treatment of tumor, cysts and soft tissue abscess when not related to another oral procedure.
h. Treatment of fractures including reduction with or without tooth immobilization and surgical approaches of the mandible, maxilla, malar and/or zygomatic arch, alveolus, (stabilization of teeth, open reduction splinting) and facial bones (complicated reduction with fixation and multiple surgical approaches).
i. Injection of antibiotics by the dentist or physician.

7. **Repairs Crowns and Dentures.** Repairs, relining, recement or adjustments of crowns, inlays, dentures and bridgework are covered. Benefits will be based on the type of dental service needed to make the prosthetic serviceable. Separate charges for repairs, relining, recement and adjustments done within six months of placement are not covered.

8. **General Anesthesia.** The administration of general anesthetic is covered only when dentally or medically necessary in conjunction with covered oral or dental surgery or for other covered dental procedures. The anesthetic agent must produce a state of unconsciousness with absence of pain sensation over the whole body. Benefits will not be paid for general anesthesia that does not meet the preceding requirement, whatever the reason.

9. **Prescription Drugs** when ordered by a physician in connection with covered dental procedures. Drugs must be considered medically or dentally necessary and require a physician’s prescription.

### Class III Major Dental Services

1. **Major Fillings and Crowns.** The following services are covered for restoration of tooth damage due to illness or injury only:
   a. Gold or other high noble metallic fillings.
   b. Inlay or onlays restorations consisting of metallic, porcelain/ceramic or composite/resin when not part of a bridge.
   c. Crown restorations consisting of resin, porcelain/ceramic or with noble metal and full cast or partially cast metal when not part of a bridge.
   d. Stainless steel crown restorations.
   e. Core Buildup, including any pins, pin retention, cast post and core, in addition to crown.

   Services must be considered appropriate and usual for the dental conditions. Services primarily for cosmetic or aesthetic purposes are not covered. Any series of treatment that involves crowns on any of the four front upper or lower teeth will automatically be considered cosmetic, unless a pretreatment review shows that a deterioration of each tooth makes other restoration methods inapplicable. Allowance for restoration procedures includes preparation, supplies, local anesthetic and normal follow-up care. Additional benefits will not be payable for any charges billed for the inclusive services.

   **NOTE:** The charge for a crown, inlay or for a gold or other high noble metallic filling will be limited to the charge for a silver, porcelain, resin or composite filling unless the tooth cannot be adequately restored by such fillings. Replacement of a crown or gold filling is covered only if the crown or filling is over five years old.

2. **Prosthodontics (prosthetics, dentures and bridgework).** Allowance for prosthetic procedures includes preparation, materials or supplies. Allowance also includes rebase, reline, recement or adjustments within six (6) months after the date of placement and other usual follow-up care. Separate charges for inclusive services will not be paid.
a. Initial or First Placement. Coverage is available for the initial placement of a denture or bridge when needed to replace one or more diseased or injured natural teeth that were extracted or lost while covered under the Plan. The denture or the bridgework must replace the missing tooth or teeth and be installed within 12 months after the date the tooth or teeth were lost or extracted. An initial placement denture or bridgework is considered an initial prosthetic when it does not replace and existing denture or bridgework. If fixed bridge is used, the abutments (crowns) will be covered only to the extent that they are needed to support the pontics that replaces the missing natural tooth.

b. Replacement or Addition of Teeth for Existing Dentures or Bridgework. Allowance for prosthetic procedures includes preparation and supplies. Allowance also includes rebase, reline, recement, adjustments within six months after placement and other usual follow-up care. Separate charges for inclusive services will not be paid. Replacement of dentures or bridgework or tooth additions to existing prosthetics are covered for:

1) Additional loss or extraction of diseased or injured natural teeth while covered under this Plan; or
2) The existing denture or bridgework has been in use at least five years and cannot be made serviceable and the person has been covered under the Plan for two or more years; or
3) The existing denture is an immediate temporary denture installed within the past twelve months and must now be replaced by a permanent denture; or
4) The existing denture is no longer serviceable due to an accidental injury requiring oral surgery or oral surgery which involves changing the position of muscle attachments, removing a tumor, cyst, torus or excess tissue.

Replacements for any other reasons are not covered. Under no circumstances will the Plan pay replacement of dentures or bridgework that can be made serviceable.

c. Temporary or Interim Prosthodontics. Temporary or interim bridgework is considered part of the total service for dentures or bridgework. Separate benefits will not be payable for this service.

3. Temporomandibular Joint Dysfunction (TMJ). Coverage is available for treatment of TMJ. However, this benefit excludes expenses related to TMJ surgery.

4. Dental surgical implants and related services. Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

Class IV Orthodontic Services

1. Any dental expense furnished in connection with the orthodontic treatment.
2. Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment, including routine x-rays, local anesthetics, and post-surgical care.
3. Active appliances, including diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.
5. Fixed or cemented appliance to control harmful habits.

1. Coverage Limitations. Coverage is limited to orthodontic services for treatment of handicapping malocclusion (usually four or more degree arch discrepancy). Benefits will not be payable for any orthodontic service which is primarily cosmetic or aesthetic.
Covered services must be incurred while the individual was enrolled in the Plan. For example, if the appliance was inserted before the effective date of coverage, benefits would not be payable for the appliance. However, coverage would be available for orthodontic adjustments incurred while eligible under the Plan.

2. **Benefit Payments/Course of Orthodontic Treatment.** Benefits will be payable on a report basis. The dentist must complete a dental form with full details of the treatment plan. The completed form must be mailed to the claims processor for benefit approval. Plan Payment will be prorated based on the available benefits for the course of treatment. Two or more courses of treatments will be considered one course of orthodontic treatment, unless separated by at least two (2) years from the date of last orthodontic treatment.

If orthodontic services are ended for any reason before the completion of the treatment course, benefits will cease at the time care ended. If the patient becomes ineligible for coverage under the Plan, benefits will not be paid for any period after the date coverage ends. If the patient is on a quarterly payment schedule, payment will only be based on that portion of the quarterly period that the patient actually received services and was eligible for Plan benefits. Charges for the replacement and/or repair of any appliance furnished under the treatment plan are not covered. Separate benefits will not be payable.

<table>
<thead>
<tr>
<th>After initial benefit payment, benefits will be paid in quarterly portions (every three months) during the remainder of the treatment course. Benefits are available only for services that are incurred while the participant is covered under the Plan.</th>
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<tbody>
<tr>
<td><strong>Initial Diagnosis, Evaluation, pre-care and appliances.</strong></td>
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<tr>
<td>Initial Plan Payment will be 15% of the total benefit allowance for the course of treatment.</td>
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<tr>
<td><strong>Monthly Treatment</strong></td>
</tr>
<tr>
<td>A monthly benefit for each month, payable at the end of each three-month period during the remainder of the orthodontic treatment course will be determined by dividing 45% of the total benefit allowance for the course of treatment by the total number of months needed to complete the treatment course.</td>
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**DENTAL EXCLUSIONS**

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

1. Charges for any device ordered while the individual was covered under the Plan and not delivered or installed within thirty (30) days after termination of coverage.
2. Transplant or reimplantation of any type including any prosthetic device attached to it. This exclusion includes reimplantation of natural tooth or teeth that has been dislodged or removed.
3. Any procedure not listed under Covered Dental Expenses.
4. Any procedure which began before the date the covered person’s dental coverage started, to include a service which is:
   a. An appliance, or modification of an appliance, for which an impression was made before such person became covered, or
   b. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered, or
   c. Root canal therapy, for which the pulp chamber was opened before such person became covered.
   X-rays and prophylaxis shall not be deemed to start a dental procedure.
5. Services, supplies or treatment that is cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or coverings placed on teeth except when used to return the tooth to normal form and function are considered cosmetic in nature.
6. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, except as provided under Orthodontic Services.

7. A service not furnished by a dentist, except:
   a. Services performed by a licensed dental hygienist under a dentist's supervision;
   b. X-rays ordered by a dentist; and
   c. Denturist.

8. Charges for over-dentures, including related root canal therapy and supportive restorations.

9. Replacement of a prosthetic which in the dentist's opinion can be repaired or does not need replacement.

10. Fixed prosthetics and/or partials. An allowance will be made for a temporary acrylic partial.

11. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.

12. Charges resulting from changing from one dentist to another while receiving treatment, or resulting from receiving care from more than one dentist for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one dentist had performed all the required dental services.

13. Charges for porcelain, gold, porcelain veneer, acrylic veneer, and precious metal crowns over primary teeth for children. An allowance will be made for an acrylic crown.


15. Charges for instruction in dental plaque control, dental hygiene, or nutritional counseling.

16. Charges for adjustments of new dentures within six (6) months of installation.

17. Charges for infection control (OSHA fees).

18. Charges for local anesthetic or analgesia including gas (nitrous oxide).

19. Charges for behavior management.

20. Dental services related to procedures that do not meet common dental standards or are related to investigative or experimental procedures or to methods not approved by the appropriate dental specialty society.

21. Dental services that are not dentally or medically necessary for the treatment of dental illness or injury. Services not prescribed as necessary by a dentist or physician.

22. Preventive care except as otherwise specifically included in the Plan.

23. Replacement or duplication of a bridge, crown or denture for one or more of the following:
   a. Made useless due to patient abuse, misuse or neglect.
   b. Lost or stolen appliance.
   c. Within five years of an initial installation or a prior replacement except as otherwise specifically included in the Plan.
   d. Which is or can be made functional or serviceable according to common dental standards.


25. Sedation or separate charges for local anesthetic. General anesthesia except as otherwise specifically included in the Plan.

26. Drugs and Medicines obtainable without a prescription or not connected with a covered dental procedure.

27. Charges more than the usual, customary, and reasonable allowance for covered services or supplies. Charges more than the allowable fee for a standard procedure or for alternate treatment covered instead of non-standard or specialized dental care.
29. Services or supplies received from a dental or medical department sponsored or maintained by, an employer, labor union or other similar person or group.
30. Services or supplies received from a hospital.
31. Services rendered by an immediate relative or household member.
32. Services or supplies to the extent that the care or payment of the care is unlawful where the patient resides or where the care was received at the time rendered.
33. Services or supplies covered under a medical plan sponsored by the District. The coordination of benefits provision does not apply in this case.
34. Services or supplies for which benefits are or can be provided because of related illness or injury arising from the past or present service of any person in the armed forces of a government.
35. Services or supplies related to an occupational injury or occupational sickness that entitles the Covered Person to benefits under a worker's compensation law or occupational disease law or similar legislation. Payment will not be made even if you do not claim the entitled benefit.
36. Services or supplies that could be provided by or paid for by any governmental program (other than Medicaid) under which you could be covered. Exception: services or supplies covered by Medicare.
37. Services or supplies received for which no charge would have been made without coverage under the Plan or for which there is no obligation to pay.
38. Services or supplies received because of an injury or sickness due to an act of war, whether declared or undeclared, or a warlike action in time of peace.
39. Service rendered for medical/dental summaries and invoice preparations or fees for completion of claim forms or fees for missed appointments, telephone consultations and fees for services not actually provided.
40. Services or supplies that are not included as covered services under the Plan or that are not rendered and billed by a qualified provider.
ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

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

EMPLOYEE ELIGIBILITY

All full-time or part-time employees regularly scheduled to work at least thirty (30) hours per work week shall be eligible to enroll for coverage under the Plan. This does not include temporary or seasonal employees.

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

EMPLOYEE ENROLLMENT

An employee must file a written application (or electronic, if applicable) with the employer for coverage hereunder for himself within thirty (30) days of becoming eligible for coverage. The employee shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder.

RETIREE ENROLLMENT

A retiree must file a written application (or electronic, if applicable) with the employer for coverage hereunder for himself within thirty (30) days of retirement. The retiree shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder.

If you declined enrollment for yourself and/or your spouse, you may not re-enroll at a later date.

EMPLOYEE(S) EFFECTIVE DATE

Eligible employees, as described in Employee Eligibility, are covered under the Plan as follows –

- If a person is hired the first of the month and submits all required paperwork by the first of the month, they can be effective for the 1st of the month.
- If hired after the 1st of the month and after all paperwork is received, the employee’s effective date is the 1st of the following month.

RETIREE EFFECTIVE DATE

Eligible retirees, as described in Retiree Eligibility, are covered under the Plan on the date of retirement.
**DEPENDENT(S) ELIGIBILITY**

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

1. The term "spouse" means the spouse of the employee/retiree under a legally valid existing marriage, as defined by the state in which the employee/retiree was legally married, unless court ordered separation exists.

   The term "domestic partner" means that the person recognized as an unmarried employee’s/retiree’s same gender partner with whom the employee/retiree has a committed long term relationship that fully meets the conditions for Domestic Partner eligibility shown below. Same-sex Domestic Partners must be married or live in a state where same-sex couples are not permitted to marry in order to be eligible for coverage.

   Domestic Partners will be considered for Plan enrollment on the same basis as a Spouse. Domestic Partners are defined as two same sex individuals who share a household and who have a relationship of financial independence and mutual care.

   The following are required for eligibility in the Bedford Central School District Health Plan:
   a. Partners must be the same sex; and
   b. Partners must be of legal age to marry in New York State; and
   c. Partners must not be related by blood to a degree of closeness which would prohibit marriage in New York State; and
   d. Partners must have resided together for at least 12 months and intend to do so indefinitely; and
   e. Partners must sign the Affidavit of Domestic Partnership; and
   f. Partners who reside in New York City must register with the City Domestic Partnership Registry and provide the District Benefits Office with the Certification of Domestic Partnership; and
   g. Partners must otherwise meet the requirements and limitations of eligibility that pertain to all employees/retirees of the Bedford Central School District:
      1. Joint ownership of property (i.e. real estate), or a joint mortgage or joint lease that is at least twelve (12) months duration.
      2. Partners have been listed on each other’s will for at least twelve months.
      3. Partners have been a beneficiary of the Employee’s ERS or TRS retirement plan for at least twelve (12) months.
      4. Partners hold general power of attorney or health care power of attorney for each other.
      5. Domestic Partnership agreement that creates a personal and financial interdependence including joint and several liability for each other’s debts and expenses and responsibility for mutual care.

   The District will require documentation of criteria shown above. An Affidavit of Domestic Partnership signed by both partners must be provided to the District Benefits Office. Affidavit forms are available from the District Benefits office.

   Eligibility ends when the Domestic Partnership no longer meets the above criteria. If criteria are no longer met, the District Benefits Office must be notified, in writing, within 30 days.
2. The employee’s natural child, stepchild, your domestic partner’s child, child placed for adoption a foster child, through the end of the month in which the child reaches twenty-six (26) years of age.

3. An eligible child shall also include any other child of an employee or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under the Plan. Such child shall be referred to as an alternate recipient. Alternate recipients are eligible for coverage only if the employee is also covered under the Plan. An application for enrollment must be submitted to the employer for coverage under the Plan. The employer/plan administrator shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the Plan pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the employer/plan administrator shall determine whether such order is a QMCSO, as defined in Section 609 of ERISA, or a NMSN, as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

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

4. A dependent child who was covered under the Plan prior to the end of the month in which the child reached twenty-six (26) years of age and who lives with the employee, is unmarried, incapable of self-sustaining employment and dependent upon the employee for support due to a mental and/or physical disability, will remain eligible for coverage under the Plan beyond the date coverage would otherwise terminate. Proof of incapacitation must be provided within thirty (30) days of the child’s loss of eligibility and thereafter as requested by the employer or claims processor, but not more than once every two (2) years.

Eligibility may not be continued beyond the earliest of the following:
   a. Cessation of the mental and/or physical disability;
   b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible employee may enroll eligible dependents. However, if both the husband and wife are employees, they may choose to have one covered as the employee, and the spouse covered as the dependent of the employee, or they may choose to have both covered as employees. Eligible children may be enrolled as dependents of one spouse, but not both.

**DEPENDENT ENROLLMENT**

An employee must file a written application (or electronic, if applicable) with the employer for coverage hereunder for his eligible dependents within thirty (30) days of becoming eligible for coverage; and within thirty (30) days of marriage or the acquiring of children or birth of a child. The employee shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder.

**DEPENDENT(S) EFFECTIVE DATE**

Eligible dependent(s), as described in Dependent(s) Eligibility, will become covered under the Plan on the later of the dates listed below, provided the employee has enrolled them in the Plan within thirty (30) days of meeting the Plan’s eligibility requirements and any required contributions are made.
1. The date the employee's coverage becomes effective.
2. The date the dependent is acquired, provided the employee has applied for dependent coverage within thirty (30) days of the date acquired.
3. Newborn children shall be covered from birth, provided the employee has applied for dependent coverage within thirty (30) days of birth.
4. Coverage for a newly adopted or to be adopted child shall be effective on the date the child is placed for adoption, provided the employee has applied for dependent coverage within thirty (30) days of the date the child is placed for adoption.

**SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)**

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

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

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

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

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

The employee or dependent must request the special enrollment and enroll no later than thirty (30) days from the date of loss of other coverage.

The effective date of coverage as the result of a special enrollment shall be the date of loss of other coverage.
SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)

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

For the purposes of this provision, the acquisition of a new dependent includes:
- marriage
- birth of a dependent child
- adoption or placement for adoption of a dependent child

The employee must request the special enrollment within thirty (30) days of the acquisition of the dependent.

The effective date of coverage as the result of a special enrollment shall be:
1. in the case of marriage, the date of such marriage;
2. in the case of a dependent's birth, the date of such birth;
3. in the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

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

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

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

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

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

OPEN ENROLLMENT

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

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

The effective date of coverage as the result of an open enrollment period will be the start of the following plan year.
Except for a status change listed below, the open enrollment period is the only time an employee may change benefit options or modify enrollment. Status changes include:

1. Change in family status. A change in family status shall include only:
   a. Change in employee's legal marital status;
   b. Change in number of dependents;
   c. Termination or commencement of employment by the employee, spouse or dependent;
   d. Change in work schedule;
   e. Dependent satisfies (or ceases to satisfy) dependent eligibility requirements;
   f. Change in residence or worksite of employee, spouse or dependent.

2. Significant change in the cost of coverage under the employer's group medical plan.

3. Cessation of required contributions.

4. Taking or returning from a leave of absence under the Family and Medical Leave Act of 1993.

5. Significant change in the health coverage of the employee or spouse attributable to the spouse's employment.

6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act of 1996.

7. A court order, judgment or decree.

8. Entitlement to Medicare or Medicaid, or enrollment in a state child health insurance program (CHIP).

9. A COBRA qualifying event.

NOTE: Open enrollment does not apply to retirees. If you declined enrollment for yourself and/or your dependents, you may not re-enroll at a later date.

ENROLLMENT CHANGES

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

1. Change in family status. A change in family status shall include only:
   a. Change in employee's legal marital status;
   b. Change in number of dependents;
   c. Termination or commencement of employment by the employee, spouse or dependent;
   d. Change in work schedule;
   e. Dependent satisfies (or ceases to satisfy) dependent eligibility requirements;
   f. Change in residence or worksite of employee, spouse or dependent.

2. Significant change in the cost of coverage under the employer's group medical plan.

3. Cessation of required contributions.

4. Taking or returning from a leave of absence under the Family and Medical Leave Act of 1993.

5. Significant change in the health coverage of the employee or spouse attributable to the spouse's employment.

6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act of 1996.

7. A court order, judgment or decree.

8. Entitlement to Medicare or Medicaid, or enrollment in a state child health insurance program (CHIP).

9. A COBRA qualifying event.
TERMINATION OF COVERAGE

Except as provided in the Plan’s Continuation of Coverage (COBRA) or any Extension of Benefits provision, coverage will terminate on the earliest of the following dates:

TERMINATION OF EMPLOYEE/RETIREE COVERAGE

1. The date the employer terminates the Plan and offers no other group health plan.

2. The last day of the month in which the employee ceases to meet the eligibility requirements of the Plan.

3. The last day of the month in which employment terminates, as defined by the employer's personnel policies.

4. The date the employee becomes a full-time, active member of the armed forces of any country.

5. The date the employee/retiree ceases to make any required contributions.

TERMINATION OF DEPENDENT(S) COVERAGE

1. The date the employer terminates the Plan and offers no other group health plan.

2. The date the employee's coverage terminates.

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

4. The date the employee ceases to make any required contributions on the dependent's behalf.

LEAVE OF ABSENCE

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

LAYOFF

Coverage may be continued for a limited time, contingent upon payment of any required contributions for employees and/or dependents, when the employee is subject to an employer layoff.

SEVERANCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for employees and/or dependents, as the result of a severance package agreement for the length of time negotiated between the employee and employer. Such coverage shall run concurrently with any available COBRA continuation coverage. In no event will coverage continue for more than eighteen (18) months after the employee’s active service ends.
DEATH

Should you die, your enrolled Dependents should contact the District Benefits Office for complete details concerning eligibility and costs for coverage under this rule.

a. All Members Prior to July 1, 2006. If an Active Employee or Retiree dies, his or her survivor Dependents who are enrolled in his or her family coverage will continue to be eligible for coverage at no cost for the three (3) months following the Employee or Retirees’ death. After three (3) months, this extension of eligibility continues to apply to survivors of eligible Retirees or survivors of eligible Employees who have completed at least ten (10) years of active service with the District. To be covered, the survivors must request enrollment within ninety (90) days after the death of the Employee or Retiree. If enrollment is not made within ninety (90) days, eligibility under this rule is not available. The premiums will be paid by those electing to participate at the group rate in effect for the District Health Care Plan. This coverage ends for the Spouse/Domestic Partner when he or she marries/remarries or forms a Domestic Partnership. For survivor children, coverage ends when they otherwise no longer meet the definition of Dependent Children. For example, reach limiting age or no longer a student. If survivors are not eligible for this extension, do not choose this extension or if coverage ends under this rule, they could be eligible for “Continuation of Coverage” shown later in this document.

b. July 1, 2006 and after for Active Employees only of the Bedford Teachers Association (BTA) and Bedford Association of School Administrators (BASA), and July 1, 2007 and after for Active Employees only of the Civil Service Employees Association (CSEA). If an Active Employee dies, his or her survivor Dependents who are enrolled in his or her family coverage will continue to be eligible for coverage at no cost to the surviving Spouse/Domestic Partner and/or survivor Dependents for the time specified below:

1. Active Employees who have completed over 10 years of employment with the District, coverage will be provided at no cost for the three (3) years following the Active Employee’s death. Following completion of the initial Coverage period, the Spouse/Domestic Partner or eligible Dependents of the Active Employee may elect to continue to participate in the Districts’ Health Care Plan. The premiums will be paid by those electing to participate at the group rate in effect for the District Health Care Plan.

2. Active Employees who have worked for the District 10 years or less, coverage will be provided at no cost for the two (2) years following the Active Employee’s death. Following completion of the initial coverage period, the Spouse/Domestic Partner or eligible Dependents of the Active Employee may elect to continue to participate in the Districts’ Health Care Plan. The premiums will be paid by those electing to participate at the group rate in effect for the District Health Care Plan.

Enrollment for survivor benefits is not automatic. To be covered, the survivors must request enrollment within 90 days after the death of the Active Employee. If enrollment is not made within ninety (90) days, eligibility under this rule is not available. This coverage ends for the Spouse/Domestic Partner when he or she marries/remarries or forms a Domestic Partnership. For survivor Children, coverage ends when they otherwise no longer meet the definition of Dependent children. For example, reach limiting age or are no longer a student. If survivors are not eligible for this extension or if coverage ends under this rule, they could be eligible for “Continuation of Coverage” shown later in this document.
FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An employee who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993 (FMLA), as amended, has the right to continue coverage under the Plan for up to twelve (12) weeks, or (twenty-six (26) weeks in certain circumstances). Employees should contact the employer to determine whether they are eligible under FMLA.

Contributions

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

Reinstatement

If coverage under the Plan was terminated during an approved FMLA leave, and the employee returns to active work immediately upon completion of that leave, Plan coverage will be reinstated on the date the employee returns to active work as if coverage had not terminated, provided the employee makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to active work.

Repayment Requirement

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

EMPLOYEE REINSTATEMENT

An employee who returns to work following an approved leave of absence, layoff, or termination of employment will be considered a new employee for purposes of eligibility and will be subject to all eligibility requirements, including all requirements relating to the effective date of coverage.
CONTINUATION OF COVERAGE

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

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits.

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a covered person to lose coverage under the Plan or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date described in Termination of Coverage:

1. Death of the employee/retiree.
2. The employee's termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the Plan. This event is referred to below as an "18-Month Qualifying Event."
3. Divorce or legal separation from the employee/retiree.
4. The employee's/retiree's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
5. A dependent child no longer meets the eligibility requirements of the Plan.
6. A covered retiree and their covered dependents whose benefits were substantially eliminated within one (1) year of the employer filing for Chapter 11 bankruptcy.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered employee/retiree, or a child's loss of dependent status, the employee/retiree or dependent must submit a completed Qualifying Event Notification form to the plan administrator (or its designee) within sixty (60) days of the latest of:
   a. The date of the event;
   b. The date on which coverage under the Plan is or would be lost as a result of that event; or
   c. The date on which the employee/retiree or dependent is furnished with a copy of this Plan Document and Summary Plan Description.

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

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

2. When eligibility for continuation of coverage results from any qualifying event under the Plan other than the ones described in Paragraph 1 above, the plan administrator (or its designee) will furnish an Election Notice to the employee/retiree or dependent not later than forty-four (44) days after the date on which the employee/retiree or dependent loses coverage under the Plan due to the qualifying event.

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

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

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

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

**COST OF COVERAGE**

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

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

**WHEN CONTINUATION COVERAGE BEGINS**

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

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

**EXTENSION OF CONTINUATION COVERAGE**

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

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

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

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

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

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

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

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

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

(i.) The date of the disability determination by the Social Security Administration;
(ii.) The date of the 18-Month Qualifying Event;

(iii.) The date on which the person loses (or would lose) coverage under the Plan as a result of the 18-Month Qualifying Event; or

(iv.) The date on which the person is furnished with a copy of the Plan Document and Summary Plan Description.

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

(A.) The date of the final determination by the Social Security Administration; or

(B.) The date on which the individual is furnished with a copy of the Plan Document and Summary Plan Description.

END OF CONTINUATION

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

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

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

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

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

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

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

7. The date the covered person first becomes covered under any other employer’s group health plan after the original date of the covered person’s election of continuation coverage.

8. For the spouse or dependent child of a covered employee who becomes entitled to Medicare prior to the spouse’s or dependent’s election for continuation coverage, thirty-six (36) months from the date the covered employee becomes entitled to Medicare.

9. A covered employee who retired on or before the date of substantial elimination of plan coverage which is the result of a bankruptcy proceeding under Title 11 of the US Code with respect to the employer, as is the spouse/domestic partner, surviving spouse/domestic partner or dependent child of such a covered employee if, on the day before the bankruptcy qualifying event, the spouse/domestic partner, surviving spouse/domestic partner or dependent child was a beneficiary under the plan.
SPECIAL RULES REGARDING NOTICES

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

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

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

MILITARY MOBILIZATION

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

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

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

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

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

PLAN CONTACT INFORMATION

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

ADDRESS CHANGES

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

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

POST-SERVICE CLAIM PROCEDURE

FILING A CLAIM

Claims should be submitted to the address shown on the ID card. The date of receipt will be the date the claim is received by the claims processor.

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

- a. Name of patient
- b. Patient’s date of birth
- c. Name of employee/retiree
- d. Address of employee/retiree
- e. Name of employer and group number
- f. Name, address and tax identification number of provider
- g. Employee/retiree CoreSource Member Identification Number
- h. Date of service
- i. Diagnosis and diagnosis code
- j. Description of service and procedure number
- k. Charge for service
- l. The nature of the accident, injury or illness being treated

Timely Filing: All claims not submitted within twelve (12) months from the date the services were rendered will be considered not timely file, will not be a covered expense and will be denied.

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

NOTICE OF AUTHORIZED REPRESENTATIVE

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

NOTICE OF CLAIM

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

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than the timely filing limit stated above, unless the claimant is legally incapacitated.
Notice given by or on behalf of a **covered person** or his beneficiary, if any, to the **plan administrator** or to any authorized agent of the **Plan**, with information sufficient to identify the **covered person**, shall be deemed notice of claim.

**TIME FRAME FOR BENEFIT DETERMINATION**

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

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

**NOTICE OF BENEFIT DENIAL**

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

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

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

**APPEALING A DENIED POST-SERVICE CLAIM**

The “**named fiduciary**” for purposes of an appeal of a denied Post-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the **claims processor**.
A **covered person**, or the **covered person’s** authorized representative, may request a review of a denied claim by making written request to the **named fiduciary** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the **covered person** feels the claim should not have been denied.

The following describes the review process and rights of the **covered person**, for a full and fair review:

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

**NOTICE OF BENEFIT DETERMINATION ON APPEAL**

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

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

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

FOREIGN CLAIMS

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

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

HEALTH CARE MANAGEMENT

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

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

FILING A PRE-CERTIFICATION CLAIM

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

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

*Covered persons* shall contact the *Health Care Management Organization* by calling the number shown on their ID card.

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

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

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

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

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

**NOTICE OF AUTHORIZED REPRESENTATIVE**

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

**TIME FRAME FOR PRE-SERVICE CLAIM DETERMINATION**

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

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

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

**CONCURRENT CARE CLAIMS**

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

If a *covered person* (or authorized representative) requests to extend a previously approved hospitalization or an ongoing course of treatment, and;

a. The request involves non-urgent care, then the extension request must be processed within fifteen (15) calendar days after the request was received.

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

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

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

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

NOTICE OF PRE-SERVICE CLAIM DENIAL

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

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

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

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

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

The following describes the review process and rights of the covered person for a full and fair review:

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

NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL

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

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

1. The specific reasons for the denial.
2. Reference to specific Plan provisions on which the denial is based.
3. A statement that the covered person has the right to access, free of charge, relevant information to the claim for benefits.
4. A statement of the covered person’s right to request an external review and a description of the process for requesting such a review.

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

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

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

CASE MANAGEMENT

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

In addition, the Health Care Management Organization may recommend (or change) alternative:
- methods of medical care or treatment;
- equipment; or
- supplies;
that differ from the medical care or treatment, equipment or supplies that are considered covered expenses under the Plan.

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

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

EXTERNAL APPEAL

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

1. Medical necessity;
2. Appropriateness;
3. Experimental or investigational treatment;
4. Health care setting;
5. Level of care; and
6. Effectiveness of a covered expense.
If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits.  

{Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.}

**RIGHT TO EXTERNAL APPEAL**

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

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

**NOTICE OF RIGHT TO EXTERNAL APPEAL**

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

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

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

**INDEPENDENT REVIEW ORGANIZATION**

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and shall be assigned to conduct the external review. The assigned IRO will timely notify the covered person in writing of the request’s eligibility and acceptance for external review.

**NOTICE OF EXTERNAL REVIEW DETERMINATION**

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

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

**EXPEDITED EXTERNAL REVIEW**

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

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

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

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

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

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

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

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

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

DEFINITIONS APPLICABLE TO THIS PROVISION

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

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

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

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

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

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

10. Labor/management trustee, union welfare, employer organization, or employee benefit organization plans.

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

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

**EFFECT ON BENEFITS**

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

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

**ORDER OF BENEFIT DETERMINATION**

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

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

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

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

4. **Dependent Children of Separated or Divorced Parents**
   When parents are separated or divorced, the birthday rule does not apply, instead:
   
   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.
   
   b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.

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

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

NOTE: For eligible post 65 retirees, benefits will be considered at the preferred provider level of benefits.

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

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

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

3. If the employee and/or dependent are also enrolled in Medicare (due to age or disability), this Plan shall pay as the primary plan. If, however, the Medicare enrollment is due to end stage renal disease, the Plan’s primary payment obligation will end at the end of the thirty (30) month “coordination period” as provided in Medicare law and regulations. If the employee and/or dependent does not elect Medicare, but is otherwise eligible due to end stage renal disease, benefits will be paid as if Medicare has been elected and this Plan will pay secondary benefits upon completion of the thirty (30) month “coordination period.”

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

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

6. For a retiree eligible for Medicare due to age, Medicare shall be the primary payor and this Plan shall be secondary. If the retiree does not elect Medicare, but is otherwise eligible due to age, benefits will be paid as if Medicare has been elected and this Plan will pay secondary benefits.

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

LIMITATIONS ON PAYMENTS

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

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

AUTOMOBILE ACCIDENT BENEFITS

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Assisting in Plan’s Reimbursement Activities. The covered person has an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the Plan with any information concerning the covered person’s other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to (a) cooperate fully in the Plan’s (or any Plan fiduciary’s)
enforcement of the terms of the Plan, including the exercise of the Plan’s right to subrogation and reimbursement, whether against the covered person or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan), (c) sign any document deemed by the plan administrator to be relevant to protecting the Plan’s subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term “information” includes any documents, insurance policies, police reports, or any reasonable request by the plan administrator or claims processor to enforce the Plan’s rights.

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

ADMINISTRATION OF THE PLAN

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

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

APPLICABLE LAW

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

ASSIGNMENT

Coverage and the covered person’s rights under this Plan may not be assigned. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding.

Payment of Benefits

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

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

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

Additional Provisions

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

BENEFITS NOT TRANSFERABLE

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

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

**CONFORMITY WITH STATUTE(S)**

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

**EFFECTIVE DATE OF THE PLAN**

The effective date of this Plan is January 1, 2018.

**FRAUD OR INTENTIONAL MISREPRESENTATION**

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

**FREE CHOICE OF HOSPITAL AND PHYSICIAN**

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

**INCAPACITY**

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

**INCONTESTABILITY**

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

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

LIMITS ON LIABILITY

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

LOST DISTRIBUTEEES

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

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

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

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

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

PLAN IS NOT A CONTRACT

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

PLAN MODIFICATION AND AMENDMENT

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

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

**PLAN TERMINATION**

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

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

**PRONOUNS**

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

**RECOVERY FOR OVERPAYMENT**

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

**STATUS CHANGE**

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

**TIME EFFECTIVE**

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

**WORKERS' COMPENSATION NOT AFFECTED**

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

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

DISCLOSURE BY PLAN TO PLAN SPONSOR

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

1. Disclose protected health information to the plan sponsor.

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

USE AND DISCLOSURE BY PLAN SPONSOR

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

OBLIGATIONS OF PLAN SPONSOR

The plan sponsor shall have the following obligations:

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

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

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

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

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

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

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

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

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

11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the plan sponsor on behalf of the Plan. Specifically, such safeguarding entails an obligation to:

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

EXCEPTIONS

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

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

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

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

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

**Accident**

An unforeseen event resulting in *injury*.

**Affordable Care Act**

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

**Alternate Recipient**

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

**Ambulatory Surgical Facility**

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

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

**Approved Clinical Trial**

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

**Centers of Medical Excellence (CME)**

Health care providers that are designated by the *claims administrator* as a selected facility for specified medical services. A provider participating in a *CME* network has an agreement in effect with the *claims administrator* at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. *CME* agree to accept the *maximum allowed amount* as payment in full for covered services.
Chemical Dependency

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

Chiropractic Care

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

Claims Processor

Refer to the Summary Plan Description (SPD) section of this document.

Close Relative

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

Coinsurance

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

Complications of Pregnancy

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

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

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

Concurrent Care

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

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

**Copay**

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

**Cosmetic Surgery**

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

**Covered Expenses**

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

**Covered Person**

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

**Custodial Care**

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

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

**Customary and Reasonable Amount**

Except as otherwise required under state or federal law, the maximum amount the Plan is obligated to pay for covered expenses provided by a:

1) preferred provider – the preferred provider negotiated rate;
2) nonpreferred provider – Anthem’s nonpreferred provider allowable amount is calculated as the lesser of:
   a) The provider’s billed charge; or
   b) An amount determined by claims processor or its vendor using one or more of the following:
      i) Publicly available data reflecting fees typically reimbursed to providers for the same or similar professional services, supplies or treatment, adjusted for geographical differences where applicable; or
      ii) Publicly available data reflecting the costs for facilities providing the same or similar services, supplies or treatment, adjusted for geographical differences where applicable, plus a margin factor; or
      iii) An amount negotiated with the nonpreferred provider for the specific services, supplies or treatment provided; or
iv) A fee which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is incurred and is comparable in severity and nature to the illness or injury. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. This amount is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges. The percentage applicable to this Plan is 90% and is applied to CPT and CDT codes using Fair Health benchmarking tables.

Dentist

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

Dependent

See the section titled Eligibility, Enrollment and Effective Date, Dependent(s) Eligibility.

Durable Medical Equipment

Medical equipment which:

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

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

Effective Date

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

Emergency

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

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

Emergency Services

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

**Employee**

A person directly involved in the regular business of and compensated for services, as reported on the individual's annual W-2 form, by the **employer**, who is regularly scheduled to work not less than the hours per work week as listed in the section titled **Eligibility, Enrollment and Effective Date, Employee Eligibility** on a **full-time** status basis.

**Employer**

The **employer** is Bedford Central School District.

**Essential Health Benefits**

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

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

**Experimental/Investigational**

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

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

**Extended Care Facility**

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

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

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

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

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

6. It is approved and licensed by Medicare.

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

**Facility**

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

**Full-time**

*Employees* who are regularly scheduled to work not less than the hours per work week as listed in the section titled Eligibility, Enrollment and Effective Date, Employee Eligibility.

**Generic Drug**

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

**Habilitative Services**

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

**Habilitative and Rehabilitative Devices**

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

**Health Care Management**

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

**Health Care Management Organization**

The individual or organization designated by the employer for the process of evaluating whether the service, supply, or treatment is medically necessary.
**Home Health Aide Services**

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

**Home Health Care**

Includes the following services: private duty nursing, skilled nursing visits, *hospice* and IV Infusion therapy.

**Home Health Care Agency**

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

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

**Hospice**

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

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

**Hospital**

An institution which meets the following conditions:

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

5. It must be approved by Medicare. This condition may be waived in the case of emergency treatment in a hospital outside of the United States.

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

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

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

Illness
A bodily disorder, disease, physical sickness, or pregnancy.

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

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

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

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

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

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

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

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

**Leave of Absence**

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

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

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

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

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

**Measurement Period**

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

**Medically Necessary (or Medical Necessity)**

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

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

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

Medicare

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

Mental and Nervous Disorder

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

Morbid Obesity

A diagnosed condition in which the body weight is one hundred (100) pounds or more over the medically recommended weight in the most recent Metropolitan Life Insurance Company tables for a person of the same height, age and mobility as the covered person, or having a BMI (body mass index) of forty (40) or higher, or having a BMI of thirty-five (35) in conjunction with any of the following co-morbidities: coronary artery disease, type II diabetes, clinically significant obstructive sleep apnea or medically refractory hypertension (blood pressure > 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management).

Named Fiduciary for Post-Service Claim Appeals

CoreSource.

Named Fiduciary for Pre-Service Claim Appeals

CoreSource.

Negotiated Rate

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

Nonparticipating Pharmacy

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

Nonpreferred Provider

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

Nurse

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

Outpatient

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

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

**Partial Confinement**

A period of at least six (6) hours but less than twenty-four (24) hours per day of active treatment up to five (5) days per week in a facility licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.
2. Treatment of mental and nervous disorders.

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

**Participating Pharmacy**

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

**Part-time**

Employees who are regularly scheduled to work less than the hours per work week as listed in the section titled Eligibility, Enrollment and Effective Date, Employee Eligibility.

**Physician**

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

**Placed For Adoption**

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

**Plan**

"Plan" refers to the benefits and provisions for payment of same as described herein. The Plan is the Bedford Central School District Employee Benefit Plan.

**Plan Administrator**

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

**Plan Sponsor**

The plan sponsor is Bedford Central School District.
**Preferred Provider**

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

**Preferred Provider Organization**

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

**Pregnancy**

The physical state which results in childbirth or miscarriage.

**Primary Care Physician (PCP)**

A licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is a general or family practitioner, pediatrician, gynecologist/obstetrician or general internist and has contracted with the network to render services, supplies and treatment to **covered persons** and to assist in managing the care of **covered persons**.

**Privacy Rule**


**Professional Provider**

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

**Qualified Prescriber**

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

**Reconstructive Surgery**

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

**Rehabilitative Services**

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

**Relevant Information**

**Relevant information**, when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:
1. Relied on in making the benefit determination; or
2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
3. That demonstrates compliance with the duties to make benefit decisions in accordance with Plan documents and to make consistent decisions; or
4. That constitutes a statement of policy or guidance for the Plan concerning the denied treatment or benefit for the covered person’s diagnosis, even if not relied upon.

**Required By Law**

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

**Retiree**

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

**NOTE:** For eligible post 65 retirees, benefits will be considered at the preferred provider level of benefits.

**Room and Board**

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

**Semiprivate**

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

**Stability Period**

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

**Total Disability or Totally Disabled**

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

**Transplant Centers of Medical Excellence maximum allowed amount (CME maximum allowed amount)**

The fee CME agree to accept as payment for covered services. It is usually lower than their normal charge. CME maximum allowed amounts are determined by Centers of Medical Excellence Agreements.

**Treatment Center**

1. An institution which does not qualify as a hospital, but which does provide a program of effective medical and therapeutic treatment for chemical dependency, and
2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or
3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:
a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
b. It provides a program of treatment approved by the physician.
c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the covered person.
d. It provides at least the following basic services:
   (i.) Room and board
   (ii.) Evaluation and diagnosis
   (iii.) Counseling
   (iv.) Referral and orientation to specialized community resources.

Urgent Care

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

Urgent Care Center

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

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

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

Variable Hour Employee

An employee as defined by Federal law, regulation and guidance.
APPENDIX A
PROGRAMS AND SERVICES

MESSAGING SERVICES

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

Note: The Relay Services Program applies to covered expenses under the Medical Expense Benefit section only.

MATERNITY PROGRAM

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

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

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

TRANSPARENCY TOOL – HEALTHCARE BLUE BOOK

Healthcare Bluebook is a web-based service, provided by CareOperative, LLC, enabling covered persons to research medical providers and facilities that offer prices which Healthcare Bluebook considers a “Fair Price” as described below. Services include the following:

Fair Price information. Healthcare Bluebook’s Fair Price analysis sets forth what covered persons should expect to pay for specific procedures in a given geographic area. The core of the Healthcare Bluebook approach is high volume, high-price-variability procedures, called ShopSmart™ procedures, such as colonoscopies, MRIs or knee arthroscopies. For such procedures, Healthcare Bluebook presents information on price ranges, the Fair Price and a list of providers ranked by their price level, allowing covered persons to identify high-value providers:

- Green means at or below the Fair Price,
- Yellow means for a slightly higher price,
- Red means for a moderately to significantly higher price.

Provider and Facility Information. Facility and related physician information, including practice details and Healthgrades quality ratings (or similar) are provided to help covered persons learn more about the providers listed for ShopSmart procedures.
ADOPTION

Bedford Central School District has caused this Bedford Central School District Health Benefit Plan (Plan) to take effect as of the first day of January 2018, Bedford, New York, New York. I have read the document herein and certify the document reflects the terms and conditions of the employee welfare benefit plan as established by Bedford Central School District.

BY: ___________________________ DATE: 11/15/18