AMENDMENT #3
CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)
TO THE CATHOLIC DIOCESE OF LEXINGTON HEALTH CARE BENEFITS PLAN

Effective April 1, 2009, the document specified above is amended by the provision set forth below:

The Special Enrollment Period portion(s) of the Eligibility, Effective Dates and Termination Provisions is hereby deleted from the Plan.

And replaced with the following provision:

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

LOSS OF HEALTH COVERAGE

Current Employees and their Dependents may have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage.

If the following conditions are met:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered; and

- You and/or Your Dependent stated in writing that the reason for declining coverage was due to coverage under another group health plan or health insurance policy; and

- The coverage under the other group health plan or health insurance policy was:

  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage is offered; or
  - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
  - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended, or in situations where an eligible person meets or exceeds a lifetime limit on all benefits, no later than 31 calendar days after a claim is denied for that reason.

- You and/or Your Dependents were covered under a Medicaid plan or state child health plan and Your or Your Dependents coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

Except as specifically stated above, nothing contained in this amendment shall alter or amend the Plan Document.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status.

If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. You must request and apply for coverage within 31 calendar days of marriage, birth, adoption or Placement for Adoption.

NEWLY ELIGIBLE FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

Current Employees and their Dependents may be eligible for a Special Enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the first day of the first calendar month following the date of marriage (Note: Eligible individuals must submit their enrollment forms prior to the Effective Date of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or

- In the case of a Dependent's birth, on the date of such birth; or

- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or

- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the first day of the first calendar month following an approved request for coverage; or

- In the case of loss of coverage, the first day of the month following the date the completed enrollment form is received by the Plan.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

Except as specifically stated above, nothing contained in this amendment shall alter or amend the Plan Document.

BY THIS AGREEMENT,

Catholic Diocese of Lexington Health Care Benefits Plan

is hereby amended as shown.

IN WITNESS WHEREOF, this instrument is executed for

Catholic Diocese of Lexington

on or as of the day and year first below written.

By_____
Catholic Diocese of Lexington

Title _____

Date_____

200767-AMD09-#3

IMPORTANT NOTICE:

BY SIGNING THIS PAGE THE EMPLOYER AGREES TO ALL SECTIONS OF THIS AMENDMENT.

ANY MODIFICATIONS MADE TO THIS AMENDMENT WILL CAUSE THIS DOCUMENT TO BECOME NULL AND VOID AND REQUIRE THAT A NEW SIGNATURE PAGE BE SIGNED.

Except as specifically stated above, nothing contained in this amendment shall alter or amend the Plan Document.

AMENDMENT #2
TO THE CATHOLIC DIOCESE OF LEXINGTON
HEALTH CARE BENEFITS PLAN

Effective January 1, 2009, the document specified above is amended by the provision set forth below:

Any reference to Fiserv Health – Benesight Inc., Fiserv Health – Benesight, Benesight, Inc. or Benesight are hereby deleted and replaced with UMR throughout the Plan.

Any reference to Fiserv Health – Benesight Medical Management or Benesight Medical Management are hereby deleted and replaced with UMR Care Management throughout the Plan.

Any reference to MEDICAL MANAGEMENT SERVICES and/or FISERV HEALTH - BENESIGHT MATERNITY MANAGEMENT PROGRAM are hereby deleted and replaced with:

UTILIZATION MANAGEMENT
And Other Medical Management Services

Utilization Management is the process of evaluating whether services, supplies or treatment meet Clinical Eligibility for Coverage and are appropriate to help ensure cost-effective care. Utilization Management can eliminate unnecessary services, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Notification requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons should call the phone number on the back of the Plan identification card to request Notification at least two weeks prior to a scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

Special Notes: The Covered Person will not be penalized for failure to obtain Notification if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

This Plan complies with the Newborns and Mothers Health Protection Act. The Notification requirement is not required for Hospital or Birthing Center stays of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Notification may be required for stays beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

Except as specifically stated above, nothing contained in this amendment shall alter or amend the Plan Document.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is:

UMR CARE MANAGEMENT
PO BOX 8042
WAUSAU WI 54402-8042
1-866-542-1108

DEFINITIONS

The following terms are used for the purpose of the Utilization Management section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Notified or Notification means a determination by the Utilization Review Organization on behalf of the Plan, with respect to whether a service, treatment, supply or facility is the most appropriate and cost-effective treatment for the care and treatment of an Illness or Injury and meets Clinical Eligibility for Coverage.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the effectiveness and appropriateness of health care services and treatment plans. Such assessment can be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING NOTIFICATION

Call the Utilization Review Organization **before** receiving services for the following:

- Confinement stay in a Hospital or Skilled Nursing Facility.
- All Confinement stays and Day Treatment (Partial Hospitalization) for Mental Health Disorders, substance abuse and chemical dependency.
- Confinement stay in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.

Note that if a Covered Person receives Notification for one facility, but then the person is transferred to another facility, Notification is also needed before going to the new facility, except in the case of an emergency (see Special Notes above).

PENALTIES FOR NOT OBTAINING NOTIFICATION

A non-Notification penalty is the amount that must be paid by a Covered Person who does not call for Notification prior to receiving certain services. A penalty of 20% will be applied to applicable claims if a Covered Person receives services but did not obtain the required Notification for:

- Confinement stay in a Hospital or Skilled Nursing Facility.
- All Confinement stays and Day Treatment (Partial Hospitalization) for Mental Health Disorders, substance abuse and chemical dependency.

The phone number to call for Notification is listed on the back of the Plan identification card.

Even though a Covered Person provides Notification to the Utilization Review Organization, that does not guarantee that this Plan will pay for the medical care. The Covered Person still needs to be eligible for coverage on the date services are provided. Coverage is also subject to all of the provisions described in this SPD.

Other Medical Management Services

Disease Management Program identifies those individuals who have a certain chronic disease and would benefit from this program. Nurse case managers telephonically work with Covered Persons to help them improve their chronic disease and maintain quality of life. Our unique approach to Disease Management identifies individuals with one or more of the seven targeted chronic conditions (asthma, coronary artery disease, and congestive heart failure, Chronic Obstructive Pulmonary Disease (COPD), depression, diabetes and hypertension). Built within our system is a predictive modeling tool, CaseAlert™ that takes the last year's worth of medical and pharmacy claims data and then identifies those Covered Persons who should be participating in the program. If claims history is not available, disease management candidates are initially identified using a Health Condition Survey. The survey is a general screening questionnaire sent to all Covered Persons age 18 and over that asks a few questions about each of the conditions managed in the program. Once claims data is available, the predictive modeling tool is used to identify candidates for the program. Program participants can also be identified through referrals from the Notification process, Covered Person self-referral, the employer or the Covered Person's Physician.

Precious Cargo℠ (Maternity Management) provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full term deliveries and decreases the cost of a long term hospital stay for both the mother and/or baby. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment to determine the member's risk level and educational need is done at that time. To increase participation, the program uses incentives to join. Covered Persons who join will receive two highly credible reference books provided by the American College of Gynecology and the American Academy of Pediatrics.

Case Management Services are designed to identify catastrophic and complex Illnesses, transplants and trauma cases. UMR Care Management's case management specialists identify, coordinate and negotiate alternative treatment plans and related costs by finding alternatives to costly Confinement stays. Opportunities are identified from the Notification review process, national criteria and system flags based on ICD-9, CPT and dollar threshold criteria. UMR Care Management works directly with the patient, family members, treating Physician and facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious Illness helps avoid major complications in the future. The Covered Person can request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

The **Health And Wellness** program provided by UMR Care Management offers Covered Persons a better understanding into the importance of taking care of their health today, so they may have a healthier future. When Covered Persons understand this and engage in healthier lifestyle choices, they are less likely to develop a chronic, costly and often debilitating condition in years to come. This program focus is on four key lifestyle choices:

- Nutrition habits – helping Covered Persons adopt healthy, balanced eating behaviors.
- Exercise habits – assisting Covered Persons with identifying ways to become more physically active.
- Weight Management – promoting safe, effective weight loss and weight management.
- Tobaccos cessation – helping Covered Persons make a quit plan and take action that is most likely to result in successful cessation.

The program enrolls higher-risk Covered Persons into health coaching where they work with a personal health coach through one-on-one telephonic sessions. The coaching includes goal setting and behavior changes that will attempt to keep the Covered Person from developing future health problems.

Except as specifically stated above, nothing contained in this amendment shall alter or amend the Plan Document.

One component of our Health and Wellness program is the Health Risk Assessment (HRA). This program identifies and stratifies populations based on current medical conditions and future risk, and also assesses the Covered Person's readiness to change. Program participants are asked general questions relating to nutrition, activity and exercise, alcohol and tobacco use, psychosocial, personal/family history, and personal health management. Participants are also asked about existing medical conditions, including arthritis, asthma, back pain, Chronic Obstructive Pulmonary Disease (COPD), depression, diabetes, heart disease, heart failure and hypertension. The HRA includes questions to assess the impact of the condition on the user's daily life by obtaining information about the severity of the condition and the Covered Person's ability to manage it, and can identify members who would benefit from health and wellness coaching, smoking cessation and weight management programs.

Other Health and Wellness program components include onsite biometric screening, personal health coaching, HRA review program and incentive program. Each component has a direct impact on program participation, outcomes and success for the member and the client.

The underlined portion(s) of the following provision are hereby added to the Plan:

DEFINED TERMS

Clinical Eligibility for Coverage – Refer to Covered Benefits below.

Covered Benefit or **Clinical Eligibility for Coverage** means treatment, services, supplies, medicines or facilities necessary and appropriate for the diagnosis, care or treatment of an Illness or Injury and that meet Clinical Eligibility for Coverage as determined by the Plan. Covered Benefits do not include those listed under the Exclusions section but include services, supplies, medicines or facilities that are:

- Generally provided in accordance with accepted medical practice and professionally recognized standards; and
- Provided safely at the appropriate level of care or services; and
- Not provided solely for the convenience of the Covered Person, his or her family, or any provider; and
- Known to be effective in improving health outcomes. For new interventions, effectiveness is determined by scientific evidence, then by professional standards, and finally by expert opinions; and
- Cost-effective for the condition, compared to alternative interventions, including no intervention. Cost-effective does not necessarily mean the lowest price.

In determining Covered Benefits, consideration is given to the customary practice of providers in the community or field of specialty. However, the fact that a provider may prescribe, order, recommend or approve a service, supply, medicine or facility does not, of itself, make the service a Covered Benefit.

AMENDMENT #1
TO THE CATHOLIC DIOCESE OF LEXINGTON
HEALTH CARE BENEFITS PLAN

Effective January 1, 2007, the document specified above is amended by the provision set forth below:

The following benefits are hereby deleted from the Plan:

SCHEDULE OF BENEFITS

MEDICAL BENEFITS			
Covered Services	**PPO Providers**	**Non-PPO Providers**	**Out-of-Area Plan**
Maternity Care			
Physician Charges			
Office Visits	100% after copayment (deductible waived)	70% after deductible	100% after copayment (deductible waived)
Copayment for initial visit only	$10	No copayment	$10
Delivery	90% after deductible	70% after deductible	90% after deductible
Hospital Charges	90% after deductible	70% after deductible	90% after deductible
Birthing Centers	90% after deductible	70% after deductible	90% after deductible

Except as specifically stated above, nothing contained in this amendment shall alter or amend the Plan Document.

and replaced with:

MEDICAL BENEFITS			
Covered Services	**PPO Providers**	**Non-PPO Providers**	**Out-of-Area Plan**
Maternity Care			
Physician Charges			
Office Visits	90% (deductible waived)	70% after deductible	90% (deductible waived)
Delivery	90% (deductible waived)	70% after deductible	90% after deductible
Hospital Charges	90% (deductible waived)	70% after deductible	90% after deductible
Birthing Centers	90% (deductible waived)	70% after deductible	90% after deductible

Except as specifically stated above, nothing contained in this amendment shall alter or amend the Plan Document.

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

CATHOLIC DIOCESE OF LEXINGTON HEALTH CARE BENEFITS PLAN

Restated January 1, 2006

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INTRODUCTION

This document is a description of Catholic Diocese of Lexington Health Care Benefits Plan (this Plan). No oral interpretations can change this Plan.

Coverage under this Plan will take effect for an eligible Employee and designated dependents when the Employee and such dependents satisfy the waiting period (if any) and all the eligibility requirements of this Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend this Plan at any time and for any reason.

Changes in this Plan may occur in any or all parts of this Plan including benefit coverage, deductibles (if any), maximums, copayments (if any), exclusions, limitations, definitions, eligibility, etc.

The Plan will consider benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, Injury, Illness or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

The Defined Terms section of this document includes terms that, when they are used within the context of the definition, will be capitalized. Not all capitalized terms contain a definition in the Defined Terms section.

If this Plan is terminated, the rights of Covered Persons are limited to covered expenses incurred before termination.

This document summarizes this Plan's rights and benefits for covered Employees and their covered dependents.

GENERAL PLAN INFORMATION

PLAN NAME:	Catholic Diocese of Lexington Health Care Benefits Plan
TYPE OF ADMINISTRATION:	Third party administration. Administrative services are provided as follows: • Medical claim administration is provided by Benesight, Inc. • The Prescription Drug program is administered by Innoviant • The Care Coordination program is administered by Benesight Medical Management. The Plan Administrator is responsible for overall administration of the Plan.
GROUP NUMBER:	200767
TAX ID NUMBER:	61-1132894
INITIAL PLAN EFFECTIVE DATE:	January 1, 1998
RESTATEMENT DATE:	January 1, 2006
CONTRIBUTIONS:	The Employer pays 100% of the cost of full-time Employee coverage. The Employee pays 100% of the cost of dependent coverage.
WAITING PERIOD:	30 days.
EFFECTIVE DATE OF COVERAGE:	The first day of the month following 30 days of work, with the exception of teachers for each new school year coverage begins September 1.
TERMINATION DATE OF COVERAGE:	The last day of the month following termination.
EMPLOYER INFORMATION:	Catholic Diocese of Lexington 1310 West Main Street Lexington, KY 40508-2048 (859) 253-1993
PLAN ADMINISTRATOR:	Catholic Diocese of Lexington 1310 West Main Street Lexington, KY 40508-2048 (859) 253-1993
CLAIMS ADMINISTRATOR:	Fiserv Health - Benesight, Inc. 973 Featherstone Road, Suite 200 Rockford IL 61107 800-648-4480
SEND CLAIMS TO:	Fiserv Health - Benesight, Inc. P.O. Box 310 Pueblo, CO 81002

HEALTH REIMBURSEMENT ACCOUNT (HRA)

The Consumer Directed Healthcare Plan (CDHP) Healthcare Reimbursement Account provides benefits paid solely by the Plan Sponsor. This account reimburses only those medical expenses that are eligible under the Medical portion of this Plan. Please refer to the Medical Benefits section of this Plan for a full explanation of eligible expenses.

The CDHP/HRA account reimburses medical expenses up to a maximum of $1,500 for participants who choose single coverage, and $2,000 for participants who choose employee plus one or family coverage except for Well Care. Once the HRA amount is fully used, there are no further benefits until the plan deductible has been met. Well Care is not reimbursed by the HRA account – it is reimbursed under the Medical portion of this Plan. If the entire amount of the HRA is not used during the Calendar Year, the remaining balance will roll-over into the next Calendar Year as follows: 35% for completing the health risk assessment and laboratory collection for Avidyn Health; an additional 15% of the remaining dollars for all members who are actively participating in the High Risk and Disease Management programs. Roll over is calculated April 1 of the following calendar year.

The HRA plan has two components. The HRA portion that pays 100% of the eligible medical expenses up to the maximums listed in the HRA Schedule of Benefits. The eligible medical expenses are then considered under the Medical portion of this Plan and are subject to the Calendar Year deductible and benefit percentages as listed in the Medical Schedule of Benefits.

Eligibility

An Employee must meet the eligibility requirements of this Plan to be eligible for HRA benefits. An Employee must elect coverage under the HRA plan.

A dependent must meet the eligibility requirements of this Plan to be eligible for HRA benefits. An Employee must elect Employee plus one or family coverage under the HRA plan for dependents to be eligible.

Refer to the related sections of this Plan for full requirements regarding eligibility, enrollment, waiting periods, Pre-Existing Conditions, termination of coverage, SELF-PAY CONTINUATION OF COVEREAGE, and other enrollment rights.

Enrollment After the Plan Year Begins

If an Employee enrolls after January 1, 2006, the HRA maximum amounts will be $1,500 for single coverage and $2,000 for Employee plus one or family coverage. If a person goes on the plan prior to June 30 of each calendar year, the full HRA amount is funded by the diocese. If a person goes on the plan with an effective date of July 1 or after, the funding of the HRA is half of the fully funded amount, $750 per single; $1,000 for each Employee plus one and $1,000 for family.

Termination

If an employee terminates their coverage under the HRA plan due to retirement from the Catholic Diocese of Lexington, the Employee may use the HRA balance not to exceed a maximum of $5,000 for qualified out of pocket medical expenses incurred while enrolled in SELF-PAY CONTINUATION OF COVERAGE offered by this Plan Sponsor or another medical plan for up to 5 years after retirement or when enrolled in another qualified medical plan, whichever occurs later.

The maximum reimbursement is equal to the unused reimbursement maximum amount remaining at termination of coverage minus any reasonable administration costs.

When the HRA benefit will be used

The HRA benefit will be considered before the Medical portion of this Plan for all eligible expenses.

Application of PPO discounts and Usual and Reasonable Charges

All medical expenses considered under the HRA benefit will be subject to PPO discounts for Participating Providers and the Usual and Reasonable Charge for non-Participating Providers.

Once the HRA amount is exhausted, the medical expense will be considered under the Medical portion of this Plan including Calendar Year deductibles, out-of-pocket expense amounts, limitations, and exclusions.

HEALTHCARE REIMBURSEMENT ACCOUNT (HRA) BENEFITS	
Health Reimbursement Benefit	
Single Coverage	$1,500
Employee Plus One (spouse or dependent)	$2,000
Family Coverage	$2,000
Note: Well Care is not reimbursed under the HRA portion of this plan. Benefits will be considered under the Medical Benefits portion of this Plan.	

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that:

- care and Treatment is Medically Necessary;
- charges are the negotiated contract rate or Usual and Reasonable;
- services, supplies and care are not Experimental, Investigational or Unproven Services.

DEDUCTIBLES PAYABLE BY PLAN PARTICIPANTS

Deductible Amount. This is an amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit.

COPAYMENTS PAYABLE BY PLAN PARTICIPANTS

A copayment is a smaller amount of money that is paid by the Covered Person. Copayments may apply to some services but not other services as indicated in the Schedule of Benefits.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the covered charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made as shown in the Schedule of Benefits. No benefits will be paid in excess of the Lifetime Maximum Benefit or any listed limit of this Plan.

MAXIMUM OUT-OF-POCKET EXPENSE

Covered charges are payable at the percentages shown until the maximum out-of-pocket expense shown in the Schedule of Benefits is reached each Calendar Year. Then, covered charges incurred by a Covered Person will be payable at 100% for the rest of the Calendar Year.

When a Family Unit reaches the maximum out-of-pocket expense, covered charges for that Family Unit will be payable at 100% for the rest of the Calendar Year.

LIFETIME MAXIMUM BENEFIT

The Lifetime maximum benefit is shown in the Schedule of Benefits.

Participating Provider Organization (PPO) Plan

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under this Plan, this Plan can afford to reimburse a higher percentage of their fees. Services provided by a participating provider are subject to the negotiated contract rate rather than Usual and Reasonable Charges.

The PPO Organizations this Plan has contracted with are:

- CHA Preferred PPO Network

Therefore, when a Covered Person uses a Participating Provider, that Covered Person will receive a higher payment from this Plan than when a Non-participating Provider is used. It is the Covered Person's choice as to which Provider to use.

Additional information about this option, as well as a procedure for obtaining a list of participating providers, will be given to covered Employees.

Emergency Care

Benefits will be provided at the EPO level of benefits when rendered by non-exclusive providers if services are the result of a Medical Emergency.

Out-of-Area Treatment

Treatment rendered while traveling or living (for purposes other than seeking medical care) "Out-of-Area" will be covered.

Out-of-Network Treatment

Other than the circumstances described above and in the Schedule of Benefits, **no benefits will be payable if care is not obtained from an exclusive provider.**

Additional information about this option, as well as a list of exclusive providers, will be given to covered Employees and updated as needed.

MEDICAL BENEFITS			
Covered Services	**PPO Providers**	**Non-PPO Providers**	**Out-of-Area Plan**
Calendar Year Deductible			
Per person	$3,000	$6,000	$3,000
Employee Plus One	$4,000	$8,000	$4,000
Per family	$4,000	$8,000	$4,000
Note: *The Calendar Year deductibles for all providers are combined.*			
Maximum eligible out-of-pocket expense			
Per person	$2,000	$4,000	$2,000
Employee Plus One	$2,500	$5,000	$2,500
Per family	$2,500	$5,000	$2,500
Note: *The following expenses will not apply toward the maximum out-of-pocket expense limit:* **(1)** *The deductible.* **(2)** *Copayments.* **(3)** *Reduced reimbursement for failure to follow Medical Management procedures.* **(4)** *Any charge excluded in the Plan Exclusions.*			
Note: *The maximum out-of-pocket expense for all providers is combined.*			
Lifetime Maximum Amount	$2,000,000		
Note: *The Lifetime maximum for all providers is combined.*			
Note: *For Covered Health Services rendered by a PPO, Non-PPO and Out-of-Area Provider, the benefits of this Plan will be provided after the deductible has been met, at the percentage of Usual and Reasonable Charges (if applicable) specified below until out-of-pocket amounts have been reached each Calendar Year. Thereafter, this Plan will provide benefits at 100% of the Usual and Reasonable Charge for the remainder of the Calendar Year for all Covered Health Services, unless otherwise specified. Any balances of charges not covered by this Plan will be the Covered Person's responsibility to pay.*			
NOTIFICATION: The Care Management Center must be notified of the following services: • All inpatient Confinements (including Hospital, Skilled Nursing, Inpatient Rehabilitation Facility and Mental Disorder/Substance Abuse Treatment Confinements) • Organ/Tissue Transplant Services • Home Health Care services • Durable Medical Equipment over $1,000 • Reconstructive Surgery **Covered charges will be reduced by 20% if timely notification is not received for inpatient Confinements. Please see the Care Coordination section of this Plan for details.**			

MEDICAL BENEFITS			
Covered Services	**PPO Providers**	**Non-PPO Providers**	**Out-of-Area Plan**
Allergy Treatment			
Injections, Testing and Serum	90% after deductible	70% after deductible	90% after deductible
Ambulance Services	90% after PPO deductible		
Chiropractic Services (limited to 20 visits per Calendar Year)	90% after deductible	70% after deductible	90% after deductible
Diagnostic X-ray and Laboratory Services			
Inpatient	90% after deductible	90% after deductible	90% after deductible
Outpatient	90% after deductible	90% after deductible	90% after deductible
Independent Lab (Outside Lab)	90% after deductible	90% after deductible	90% after deductible
Durable Medical Equipment	90% after deductible	90% after deductible	90% after deductible
Emergency Room Hospital and Physician Services			
Medical Emergency	90% after deductible	90% after deductible	90% after deductible
Non-Medical Emergency	90% after deductible	70% after deductible	90% after deductible
Note: *Non-PPO Emergency Room Hospital and Physician services rendered for a Medical Emergency will be payable at the PPO level of benefits if choice of Hospital was beyond the control of the Covered Person.* ***Note:*** *Covered services provided by a Radiologist, Anesthesiologist or Pathologist when rendered in a PPO Hospital will be payable at the PPO level of benefits.*			
Home Health Care (limited to 100 visits per Calendar Year)	90% after deductible	70% after deductible	90% after deductible
Note: *A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or up to four (4) hours of home health aide services.*			
Hospice Care (limited to 6 months per Lifetime)	90% after deductible	70% after deductible	90% after deductible

MEDICAL BENEFITS			
Covered Services	**PPO Providers**	**Non-PPO Providers**	**Out-of-Area Plan**
Hospital Services			
Inpatient	90% after deductible	70% after deductible	90% after deductible
Daily Room and Board limited to the average semi-private room rate.			
Intensive Care Unit limited to Hospital's ICU charge.			
Outpatient	90% after deductible	70% after deductible	90% after deductible
***Note:** Covered services provided by a Radiologist, Anesthesiologist or Pathologist when rendered in a PPO Hospital will be payable at the PPO level of benefits.*			
Injury to or Care of Mouth, Teeth and Gums	90% after deductible	90% after deductible	90% after deductible
Inpatient Rehabilitation Facility Services	90% after deductible	70% after deductible	90% after deductible
Maternity Care			
Physician Charges			
Office Visits	100% after copayment (deductible waived)	70% after deductible	100% after copayment (deductible waived)
Copayment for initial visit only	$10	No copayment	$10
Delivery	90% after deductible	70% after deductible	90% after deductible
Hospital Charges	90% after deductible	70% after deductible	90% after deductible
Birthing Centers	90% after deductible	70% after deductible	90% after deductible
Morbid Obesity	90% after deductible	70% after deductible	90% after deductible
Coverage includes diagnostic services and surgical procedures.			

MEDICAL BENEFITS			
Covered Services	**PPO Providers**	**Non-PPO Providers**	**Out-of-Area Plan**
Occupational Therapy			
Outpatient	90% after deductible	70% after deductible	90% after deductible
Office	100% after copayment (deductible waived)	70% after deductible	100% after copayment (deductible waived)
Copayment per visit	$10	No copayment	$10
Orthotics	90% after deductible	70% after deductible	90% after deductible
Outpatient Private Duty Nursing Care	90% after deductible	70% after deductible	90% after deductible
Physical Therapy (limited to 30 visits per Calendar Year; limit applies to office services)			
Outpatient	90% after deductible	70% after deductible	90% after deductible
Office	100% after copayment (deductible waived)	70% after deductible	100% after copayment (deductible waived)
Copayment per visit	$10	No copayment	$10
Physician Office Services	100% after copayment (deductible waived)	70% after deductible	100% after copayment (deductible waived)
Copayment per office visit (applies to the office visit only)	$10	No copayment	$10
All other Physician office services	90% after deductible	70% after deductible	90% after deductible
Note: *Services provided in a Physician's office that are otherwise shown in the Schedule of Benefits are not covered under this benefit.* *Related outpatient Non-PPO diagnostic x-ray and lab services that are incurred as a result of a PPO Physician office visit will be payable at the PPO level of benefits.*			
Podiatry	90% after deductible	70% after deductible	90% after deductible
Pre-Admission Testing	90% after deductible	70% after deductible	90% after deductible

MEDICAL BENEFITS			
Covered Services	**PPO Providers**	**Non-PPO Providers**	**Out-of-Area Plan**
Prosthetics	90% after deductible	70% after deductible	90% after deductible
Second or Third Surgical Opinion	90% after deductible	70% after deductible	90% after deductible
Skilled Nursing Facility – Inpatient Services (limited to 60 days per Calendar Year) *Covered daily charge limited to the facility's semi-private room rate.*	90% after deductible	70% after deductible	90% after deductible
Sleep Disorders (obstructive sleep apnea only) *Coverage includes diagnostic services, surgical procedures and non-surgical procedures.*	90% after deductible	70% after deductible	90% after deductible
Speech Therapy (limited to 20 visits per Calendar Year; limit applies to office services)			
Outpatient	90% after deductible	70% after deductible	90% after deductible
Office	100% after copayment (deductible waived)	70% after deductible	100% after copayment (deductible waived)
Copayment per visit	$10	No copayment	$10
Surgery			
Surgeon, assistant surgeon and anesthesiologist services			
Inpatient Services	90% after deductible	70% after deductible	90% after deductible
Outpatient Services	90% after deductible	70% after deductible	90% after deductible
Outpatient Surgery Facility	90% after deductible	70% after deductible	90% after deductible
Surgery performed in a Physician's Office	90% after deductible	70% after deductible	90% after deductible

MEDICAL BENEFITS			
Covered Services	**PPO Providers**	**Non-PPO Providers**	**Out-of-Area Plan**
Temporomandibular Joint (TMJ) Syndrome (limited to $5,000 maximum payable per Lifetime) *Coverage includes diagnostic services, surgical procedures and non-surgical procedures.*	90% after deductible	70% after deductible	90% after deductible
Urgent Care Facility	90% after deductible	70% after deductible	90% after deductible
Vision Exams (limited to one exam per Calendar Year)	90% after deductible	90% after deductible	90% after deductible
Well Care – Age 19 and Over (limited to $600 maximum payable per Calendar Year) *Coverage includes routine physical exam, school physical, Pap smear, gynecological exam, mammogram, prostate exam and related lab tests (i.e., PSA), x-rays, laboratory tests (i.e., urinalysis, blood tests) and immunizations.* Mammogram Schedule: • Ages 35 through 39; one Baseline exam • Age 40 and over; one every year ***Note:*** *Colon exam (colonoscopy) expenses do not accrue toward the well-care limitation.*	100% (deductible waived)	70% after deductible	100% (deductible waived)
Well Child Care – Age 18 and Under (limited to $550 maximum payable per Calendar Year) *Coverage includes routine physical exam, school physical, laboratory tests (i.e., urinalysis, blood work, etc.), x-rays, immunizations and hearing exam.*	100% (deductible waived)	70% after deductible	100% (deductible waived)
Wigs – after chemotherapy (limited to $200 maximum payable per Lifetime)	90% after deductible	90% after deductible	90% after deductible

MEDICAL BENEFITS			
Covered Services	**PPO Providers**	**Non-PPO Providers**	**Out-of-Area Plan**
Mental Disorders (Physician visits are limited to one per day)			
Inpatient Care (limited to 30 days per Calendar Year and limited to one admission every 6 months; limit combined with Partial Hospitalization limit)	90% after deductible	70% after deductible	90% after deductible
Partial Hospitalization (limited to 60 days per Calendar Year and limited to one admission every 6 months; combined with inpatient care limits; two days of Partial Hospitalization are equal to one day of inpatient care)	90% after deductible	70% after deductible	90% after deductible
Office/Outpatient Care (limited to 30 visits per Calendar Year)	90% after deductible	70% after deductible	90% after deductible
Substance Abuse Treatment (Physician visits are limited to one per day)			
Inpatient Care (limited to 30 days per Calendar Year and limited to one admission every 6 months; limit combined with Partial Hospitalization limit)	90% after deductible	70% after deductible	90% after deductible
Partial Hospitalization (limited to 60 days per Calendar Year and limited to one admission every 6 months; combined with inpatient care limits; two days of Partial Hospitalization are equal to one day of inpatient care)	90% after deductible	70% after deductible	90% after deductible
Office/Outpatient Care (limited to 30 visits per Calendar Year)	90% after deductible	70% after deductible	90% after deductible
Lifetime Maximum Payable (Inpatient/Outpatient/Office Care combined)	$25,000		
All Other Covered Expenses	90% after deductible	70% after deductible	90% after deductible

Note: *Treatment rendered while traveling or living (for purposes other than seeking medical care) "Out-of-Area" will be paid at the Out-of-Area level of benefits, subject to the deductible and the maximum out-of-pocket expense. "Out-of-Area" is defined as 30 miles or more from the nearest PPO Hospital or Physician.*

Charges for services rendered by a Provider whose specific specialty is not available in the PPO area will be considered at the PPO level of benefits, subject to the deductible and the maximum out-of-pocket expense.

ORGAN/TISSUE TRANSPLANT BENEFITS		
Covered Services	**URN Facility**	**Non-URN Facility**
Percentage payable during a Benefit Period for Approved Transplant Services	90% after PPO deductible	70% after Non-PPO deductible
Transportation/Accommodations (up to a combined maximum of $10,000 per Transplant Benefit Period – daily combined maximum of $200 for lodging and meals)	90% after PPO deductible	Not covered
Organ/Tissue Procurement and Acquisition	90% after PPO deductible	70% after Non-PPO deductible
Organ Transplant Lifetime Maximum Payable	Overall Plan Lifetime Maximum	The lesser of $100,000 per transplant or the remaining Overall Plan Lifetime Maximum
Note: *Covered charges for Approved Transplant Services incurred at an URN Facility are subject to the PPO deductible and maximum out-of-pocket expense.* *Covered charges for Approved Transplant Services incurred at a Non-URN Facility are subject to the Non-PPO deductible and maximum out-of-pocket expense.*		

PRESCRIPTION DRUG BENEFITS	
Covered Services	**Percentage and/or Dollar Amount**
Pharmacy Option – Innoviant Copayment per Prescription (34-day supply)	
Generic Product	$10
Preferred Brand Name Product	$30
Non-Preferred Brand Name Product (limited to a minimum of $50 and a maximum of $100)	50%
Mail Order Prescription Drug Option – Innoviant Copayment per Prescription (90-day supply)	
Generic Product	$20
Preferred Brand Name Product	$60
Non-Preferred Brand Name Product (limited to a minimum of $100 and a maximum of $200)	50%
Note: *If the Covered Person chooses a Brand Name Product when the equivalent Generic Product is available, the Covered Person will pay the difference in cost between the Brand Name and the Generic Product, plus the Brand Name Product copayment. If the Covered Person's Physician has indicated that a Brand Name Product be dispensed as written (DAW), the Covered Person will not be charged the difference between the Brand Name and the Generic Product.*	

MEDICAL MANAGEMENT SERVICES

Benesight Medical Management:
(888) 413-0934

The patient or family member must call this number to pre-certify certain Medical Management Services. This call must be made at least five business days in advance of services being rendered or within 2 business days after an emergency.

Any reduced reimbursement due to failure to follow Medical Management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(1) Pre-certification of Medical Necessity for the following non-emergency services before medical and/or surgical services are provided:

- Inpatient Hospital, Skilled Nursing Facility, and Inpatient Rehabilitation Facility Confinements (see special Pregnancy requirements below).
- Inpatient Mental Disorder and Substance Abuse Treatment Confinements

Note: *Inpatient Confinements for delivery of a child - the utilization review administrator must be notified only if the inpatient care for the mother or child is expected to continue beyond:*

- *48 hours following a normal vaginal delivery or*
- *96 hours following a cesarean section*

Pregnancy Requirements

Inpatient Confinements for delivery of a child - the utilization review administrator must be notified only if the inpatient care for the mother or child is expected to continue beyond:

- 48 hours following a normal vaginal delivery or
- 96 hours following a cesarean section

Inpatient care beyond these limits - Fiserv Health - Benesight Medical Management must be notified before these time periods.

Confinement during Pregnancy prior to the admission for delivery - Fiserv Health - Benesight Medical Management must be notified prior to the scheduled admission.

Group health plans and health insurance issuers 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 48 hours following a vaginal delivery, or less than 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 the newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from this Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(2) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(3) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(4) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical Treatment.

The purpose of the program is to determine what services are eligible under this Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that this Plan will not consider that course of treatment as appropriate for the maximum reimbursement under this Plan.

In order to maximize Plan reimbursements, read the following provisions carefully.

Here's how the program works.

Pre-certification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, Fiserv Health - Benesight Medical Management will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact Benesight Medical Management at the telephone number on the Covered Person's ID card **at least 5 business days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee;
- The name, Social Security number and address of the covered Employee;
- The name of the Employer;
- The name and telephone number of the attending Physician;
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay; and
- The diagnosis and/or type of surgery.

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact Benesight Medical Management **within 2 business days** of the first business day after the admission.

Fiserv Health - Benesight Medical Management will determine the number of days of a Medical Care Facility Confinement authorized for benefit consideration. **Failure to follow this procedure will reduce reimbursement received from this Plan.**

> ***If the Covered Person does not receive authorization for inpatient Confinements as explained in this section, and the services are determined to be Medically Necessary, covered facility charges will be reduced by 20%. Any reduced reimbursement due to failure to follow medical management procedures will not accrue toward the maximum out-of-pocket expense.***

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are part of the utilization review program. Fiserv Health - Benesight Medical Management will monitor the Covered Person's Medical Care Facility stay or use of other medical services. Fiserv Health - Benesight Medical Management will also coordinate with the attending Physician, Medical Care Facilities, and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is medically necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days.

APPEALING A UTILIZATION REVIEW DECISION

If a patient and/or Physician does not agree with the utilization review administrator's decision, it can be appealed. Refer to the Claim Procedures section of your Summary Plan Description for a complete description of your rights under the appeal process.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- Personal support to the patient;
- Contacting the family to offer assistance and support;
- Monitoring Hospital or Skilled Nursing Facility care;
- Determining alternative care options; and
- Assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and this Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct this Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by this Plan.

Note: *Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.*

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

If medical Case Management recommendations result in a cost savings, services will be covered under this Plan and will override any Plan limitations and/or exclusions.

DISEASE MANAGEMENT

Benesight Disease Management is a service that provides ongoing health management support to Covered Persons with chronic medical conditions such as asthma, diabetes, and cardiac disease. A Covered Person with a chronic Illness may be contacted by the Disease Management nurse to offer the service, or a Covered Person can access the service by calling (888) 413-0934.

This program is not mandatory and a Covered Person must be registered to participate. When a Covered Person registers in the program, a Disease Management nurse with experience and expertise with the particular chronic disease is assigned. The Disease Management nurse works with the Covered Person to help them achieve goals or outcomes that have been prescribed by their health care provider. The nurse will also provide counseling, and a better understanding of the condition. The Covered Person will receive information about preventing complications or crises. The Disease Management nurse will support and help the Covered Person to set and achieve goals that will meet the objectives for the Treatment prescribed by their Physician.

ALTERNATE CARE

Alternate benefit plans implemented must be beneficial to both the Covered Person and this Plan. The Care Management Center would coordinate and implement a plan by providing guidance and information on available resources and suggest the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to any alternate benefit plan. Once agreement has been reached, the Plan Administrator will direct this Plan to reimburse for health care services as stated in the treatment plan, even if these expenses normally would not be paid by this Plan.

Participation in an alternative treatment plan is voluntary. There are no reductions of benefits or penalties if the patient and family choose not to participate.

FISERV HEALTH - BENESIGHT MATERNITY MANAGEMENT PROGRAM

The Fiserv Health - Benesight Maternity Management Program is a voluntary educational program for covered expectant mothers. When an expectant mother calls Fiserv Health - Benesight Medical Management, a review specialist uses a series of automated screening questions to determine potential risk factors which prompt referral to a case management program. Expectant mothers who enroll in the Fiserv Health - Benesight Maternity Management Program will receive a complimentary maternity resource guide.

The Fiserv Health - Benesight Maternity Management Program promotes:

- Compliance with Physician's treatment plan
- Physician – patient discussions
- Self-care and healthy behavior during Pregnancy
- Well baby care and immunizations
- Understanding of normal and abnormal Pregnancy related conditions.

Covered expectant mothers who enroll that have enhanced education or case management needs will be contacted throughout their Pregnancy (frequency to be determined on a case by case basis).

Participation in the Fiserv Health - Benesight Maternity Management Program is voluntary and there is no extra benefit for participating, nor is there a penalty for not participating.

ELIGIBILITY, EFFECTIVE DATES AND TERMINATION PROVISIONS

ELIGIBILITY

Eligibility Requirements and Effective Date of Employee Coverage. A person is eligible for Employee coverage if he or she:

(1) Is a full-time Employee of the Employer. An Employee is considered to be full-time if he or she normally works at least 15 hours per week for at least 5 months, and is on the regular payroll of the Employer for that work.

(2) Is an Employee of the Employer and is an Instructor, Non-Instructor, Seminarian, or Deacon acting as a human service provider.

(3) Completes the employment waiting period of 30 consecutive days as an Employee. The waiting period is counted in the Pre-Existing Conditions exclusion time.

An Employee's coverage will take effect on the first day following satisfaction of the waiting period and all other Eligibility and Enrollment Requirements of this Plan.

Eligibility Requirements and Effective Date of Dependent Coverage.

A person is eligible for dependent coverage if he or she:

(1) Is a covered Employee's spouse or unmarried child(ren) from birth to the limiting age of 19 years. The dependent child(ren) must be primarily dependent upon the covered Employee for support and maintenance. However, a dependent child will continue to be covered after age 19, provided the child is a full-time student at an accredited school, college, university, vocational school, or educational institution, primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 25. When the child reaches either limiting age, coverage will end on the last day of the child's birthday month.

Cessation of full-time school attendance shall terminate dependent status EXCEPT that:

(a) If cessation is due to school vacation (either summer vacation or a semester/quarter chosen by the dependent during the school year), dependent status shall terminate on the date the school reconvenes if attendance does not resume; or

(b) If cessation is due to disability which prevents full-time school attendance, dependent status shall terminate on the last day of the quarter/semester in which the disability occurred.

The term "spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child, in anticipation of adoption of the child. Coverage of these pre-adoptive children is required by the federal Omnibus Budget Reconciliation Act of 1993 and no Pre-Existing Conditions limitation provision is applied to this coverage. The child must be available for adoption and the legal process must have commenced.

As required by the federal Omnibus Budget Reconciliation Act of 1993, any child of a covered

Employee who is an alternate recipient under a qualified medical child support order (QMCSO) shall be considered as having a right to dependent coverage under this Plan with no Pre-Existing Conditions provisions applied. Upon request, a Covered Person may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

(2) Is a covered dependent child who is Totally Disabled, incapable of self-sustaining employment by reason of mental retardation or physical handicap, primarily dependent upon the covered Employee for support and maintenance, unmarried and covered under this Plan when reaching the limiting age. The Plan Administrator may require, at reasonable intervals during the two years following the dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such dependent examined by a Physician of the Plan Administrator's choice, at this Plan's expense, to determine the existence of such incapacity.

These persons are excluded as dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former spouse of the Employee; or any person who is on active duty in any military service of any country.

If an Employee qualifies as both an Employee and a dependent, such person may be covered as an Employee or dependent but not as both.

If a person who is covered under this Plan changes status from Employee to dependent or dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles (if applicable) and all amounts applied to maximums.

If both husband and wife are Employees, their children will be covered as dependents of the husband or wife, but not of both.

A dependent will become effective for coverage under this Plan on the day that the Employee is eligible for coverage and the dependent satisfies all Eligibility and Enrollment Requirements of this Plan.

At any time, this Plan may require proof that a spouse or a child qualifies or continues to qualify as a dependent as defined by this Plan.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by completing an enrollment application. The covered Employee is required to enroll for dependent coverage if coverage for dependents is desired. Separate enrollment for a newborn child is required when the covered Employee already has dependent coverage.

Timely or Late Enrollment

(1) The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under this Plan and the Employee who is covering the dependent child terminates coverage, the dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

(2) An enrollment is “late” if it is not made on a “timely basis” or during a Special Enrollment Period. Late Enrollees may enroll under this Plan only during an Open Enrollment Period.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under this Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under this Plan and the first day of coverage is not treated as a waiting period. Coverage for Late Enrollees begins as specified under "Open Enrollment."

Special Enrollment Period. An eligible dependent of a covered Employee or an Employee who is eligible for coverage under this Plan, shall be permitted to enroll for coverage under this Plan if:

(1) The Employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the Employee or dependent; and

(2) The Employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if at such time this Plan required such a written statement and this Plan provided the Employee with notice of the requirement (and the consequences of the requirement); and

(3) The Employee or dependent at the time coverage was declined by the Employee or dependent:

(a) Was covered under a SELF-PAY CONTINUATION OF COVERAGE provision and the coverage under such provision terminated for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with this Plan; or

(b) Was not covered under a SELF-PAY CONTINUATION OF COVERAGE provision and either the coverage under the group health plan or health insurance coverage was terminated as a result of loss of eligibility for coverage or employer contributions toward such coverage were terminated. Some examples of “loss of eligibility” are:

- Divorce or legal separation.
- Dependent child attaining the maximum age to be eligible as a dependent child under the plan.
- Death of the Employee.
- Termination of employment or reduction in the number of hours of employment.
- The Employee or dependent exhaust the maximum lifetime benefit available under group health plan or other health insurance coverage.
- The Employee or dependent experiences a loss of coverage (i.e., terminated coverage with no substitute coverage available/offered).

and

(4) The Employee requested such enrollment no later than 31 days after the date of exhaustion of coverage described in paragraph **(3)(a)** or **(3)(b)** above and provided acceptable written evidence that health coverage under the other group health plan did exist, the names of the individuals who were covered under such group health plan, the level of coverage under the other group health plan (individual or family), type of coverage (medical, dental, etc.) and the date the coverage terminated.

In such instances, coverage shall become effective on the first day of the calendar month following enrollment and such person will not be considered a Late Enrollee under this Plan.

Family Status Change. An eligible dependent of a covered Employee, or an Employee who is eligible for coverage under this Plan, shall be permitted to enroll for coverage under this Plan if:

(1) The Employee is a Covered Person or the Employee has met any waiting period applicable to becoming covered under this Plan and is eligible to be enrolled in this Plan, but when previously eligible, had declined enrollment for coverage under this Plan; and

(2) A person becomes a dependent of the Employee through marriage, birth, adoption or placement for adoption

then, the dependent (and, if not otherwise enrolled, the Employee) may be covered under this Plan as a dependent of the Employee. In the case of the birth or adoption of a child, the spouse of the Employee may be covered as a dependent of the covered Employee if otherwise eligible for coverage.

In these instances, application for coverage must be made within 31 days after the date of marriage, birth, adoption or placement for adoption. If application is made within this time period, coverage becomes effective on the date of such birth, adoption or placement for adoption or, in the case of marriage, becomes effective on the first day of the calendar month after the request for coverage is received. In all cases such person will not be considered a Late Enrollee under this Plan.

Open Enrollment. Every September during the annual open enrollment period, eligible Employees and their dependents who are Late Enrollees will be able to enroll for coverage under this Plan. Also, covered Employees and their covered dependents will be able to make a change in coverage

Benefit choices made during the open enrollment period will become effective October 1 and remain in effect unless the Employee or dependent qualifies to enroll during a Special Enrollment Period (please see the “Special Enrollment Periods” subsection above).

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverage(s).

Employees will receive detailed information regarding open enrollment from their Employer.

TERMINATION OF COVERAGE

Note: *When coverage under this Plan stops, Covered Persons will receive a certificate that will show the period of coverage under this Plan. Covered Persons should contact the Plan Administrator for further details.*

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

(1) The date this Plan is terminated.

(2) The last day of the calendar month the covered Employee ceases to be eligible under this Plan. This includes death or termination of employment of the covered Employee.

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

In certain circumstances, a covered Employee may be eligible for SELF-PAY CONTINUATION OF COVERAGE. For a complete explanation of when SELF-PAY CONTINUATION OF COVERAGE is available, what conditions apply and how to select it, refer to the section entitled SELF-PAY CONTINUATION OF COVERAGE Options in this document.

Continuation During Family and Medical Leave. This Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, the Pre-Existing Conditions limitation provision and other waiting periods will not be imposed unless they were in effect for the Employee and/or his or her dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of an Employee returning to work directly from SELF-PAY CONTINUATION OF COVERAGE. This Employee does not have to satisfy any employment waiting periods and/or Pre-Existing Conditions limitation provisions.

Employees on Military Leave. Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no Pre-Existing Conditions limitation exclusion applied in this Plan upon return from service. If, however, the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. These rights apply only to Employees and their dependents covered under this Plan before leaving for military service.

Employees electing coverage prior to December 10, 2004, receive up to 18 months of extended health care coverage. Employees electing coverage on or after December 10, 2004, receive up to 24 months of extended health care coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the SELF-PAY CONTINUATION OF COVERAGE Section, to the extent these SELF-PAY CONTINUATION OF COVERAGE requirements do not conflict with USERRA.

Plan exclusions and waiting periods will not be imposed for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

When Dependent Coverage Terminates. A dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered dependent may be eligible for SELF-PAY CONTINUATION OF COVERAGE. For a complete explanation of when SELF-PAY CONTINUATION OF COVERAGE is available, what conditions apply and how to select it, refer to the section entitled SELF-PAY CONTINUATION OF COVERAGE Options):

(1) The date this Plan or dependent coverage under this Plan is terminated.

(2) The date that the Employee's coverage under this Plan terminates for any reason including death. (Refer to the section entitled SELF-PAY CONTINUATION OF COVERAGE Options.)

(3) The date a covered spouse loses coverage due to loss of dependency status. (Refer to the section entitled SELF-PAY CONTINUATION OF COVERAGE Options.)

(4) On the day that a dependent child ceases to be a dependent as defined by this Plan, unless otherwise stated. (Refer to the section entitled SELF-PAY CONTINUATION OF COVERAGE Options.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

PRE-EXISTING CONDITIONS

Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred twelve (12) consecutive months after the person's Enrollment Date, or eighteen (18) consecutive months if a Late Enrollee. This time may be offset if the person has Creditable Coverage.

NOTE: *Please see the Defined Terms section for a complete definition of a Pre-Existing Condition*

Waiver of the Pre-Existing Condition Limit. This waiver applies to the benefits of persons who were covered under a prior terminated plan on its day of termination and became covered under this Plan on the effective date of this Plan.

The prior plan means the plan of benefits that was provided through the Employer and is replaced by this Plan.

The amount of time these persons were covered under the previous plan will be credited toward the Pre-Existing Conditions time limit of this Plan.

Note: *The length of Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan.*

An eligible person may request a certificate of Creditable Coverage from his or her prior plan.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

The Pre-Existing Condition Limitation will apply to newborn, adopted, or child(ren) placed for adoption if there is a lapse of Creditable Coverage for a period of 63 days or more.

MEDICAL BENEFITS

COVERED CHARGES

Medical Benefits apply when covered charges are incurred by a Covered Person for care of an Injury or Illness and while the person is covered under this Plan.

Covered charges for PPO Providers are the negotiated contract rates, and for Non-PPO or Out-of-Area Providers are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and all other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and all other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

Changes for the health care services and supplies described in this section which meet the definition of Medically Necessary, are provided by or under the direction of a Physician or other appropriate provider as specifically described herein, and are not listed under the Plan Exclusions section of this Plan are considered eligible charges under this Plan.

(1) Abortion

Non-elective induced abortion when the life of the mother is endangered by the continued Pregnancy.

(2) Allergy Treatment

Allergy Treatment consisting of injections, testing, and serum.

(3) Ambulance Services

Local Medically Necessary professional land or air ambulance service. This will be a covered charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary Treatment can be provided.

(4) Anesthetics

Anesthetics and their professional administration.

(5) Blood, Blood Derivatives and Other Fluids

Blood and blood derivatives that are not donated or replaced; intravenous injections, and solutions. Administration of these items is included.

(6) Cardiac Rehabilitation

Cardiac rehabilitation, provided services are rendered: (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other Treatment for the medical condition ends; and (d) in a Medical Care Facility.

(7) Chemotherapy/Radiation

Chemotherapy or radiation and Treatment with radioactive substances. The materials and services of technicians are included.

(8) Chiropractic Care

Chiropractic services/spinal manipulation by a licensed MD, DO or DC. Massage therapy when performed by a licensed Doctor of Chiropractic in connection with covered chiropractic services is also included under this benefit. Services must improve a body function. Covered charges do not include Maintenance Therapy.

(9) Contact Lenses

Initial contact lenses or glasses required following cataract surgery.

(10) Cornea Transplants

Cornea transplants and all related covered charges when incurred by a Covered Person who is the recipient of such transplant.

This benefit includes organ and tissue procurement from a donor consisting of removal, surgical storage, and transportation costs incurred which are directly related to the donation of an organ used in a covered transplant procedure.

In addition to the Plan Exclusions of this Plan, benefits are not provided for:

(a) Travel expenses; or

(b) Services, chemotherapy, supplies, drugs, and aftercare for, or related to, artificial or non-human organ implants or transplants.

(11) Diagnostic X-ray and Laboratory Services

Diagnostic x-ray and laboratory services, excluding dental x-rays.

(12) Durable Medical Equipment

Rental, not to exceed the purchase price, of Durable Medical Equipment or surgical equipment. These items may be purchased rather than rented, but only if agreed to in advance by the Plan Administrator.

(13) Emergency Room Hospital and Physician Services

Emergency room services for stabilization or initiation of Treatment of a Medical Emergency or non-Medical Emergency condition provided on an outpatient basis at a Hospital.

(14) Home Health Care

Part-time, intermittent Skilled Care Services provided by a Home Health Care Agency when a Hospital or Skilled Nursing Facility Confinement would otherwise be required. The diagnosis, care and Treatment must be:

(a) certified by the attending Physician;

(b) contained in a Home Health Care Plan;

(c) provided where the Covered Person resides; and

(d) provided by or under the supervision of a registered nurse.

(15) Hospice Care

Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six (6) months, and placed the person under a Hospice Care Plan.

Bereavement counseling services by a licensed social worker (LSW) or a licensed pastoral counselor for the patient's immediate family (covered spouse and/or covered dependent children) are also covered under this benefit. Bereavement services must be furnished within 6 months after the patient's death.

(16) Hospital Services

The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a Confinement will be considered an inpatient Confinement.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

Inpatient private duty nursing services by a licensed nurse (RN, LPN or LVN) when care is not Custodial in nature and the Intensive Care Unit is filled or the Hospital has no Intensive Care Unit are also eligible.

(17) Injury to or Care of Mouth, Teeth and Gums

Treatment of Injury to or care of the mouth, teeth, gums, and alveolar processes will be covered only if that care is for the following:

(a) Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.

(b) The following surgical procedures:

(i) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(ii) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;

(iii) Excision of benign bony growths of the jaw and hard palate;

(iv) External incision and drainage of cellulitis; or

(v) Incision of sensory sinuses, salivary glands or ducts.

(c) Removal of fully and partially impacted wisdom teeth.

(d) Reduction of dislocations and excision of temporomandibular joints (TMJ's).

Dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, and preparing the mouth for the fitting of or continued use of dentures are not eligible under Medical Benefits.

(23) Inpatient Rehabilitation Facility Services

Confinement in an Inpatient Rehabilitation Facility, including medical services and supplies provided during such Confinement. Benefits are available only for the care and Treatment of an Illness or Injury when a Hospital Confinement would otherwise be required.

(25) Maternity Care

Prenatal care, delivery and postnatal care for Treatment of Pregnancy are covered for a Covered Person.

Coverage for a Hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother (if a Covered Person) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. Coverage for a Hospital stay in connection with childbirth following a cesarean section may not be limited to less than 96 hours for both the mother (if a Covered Person) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician.

(26) Medical Supplies

Medical supplies administered and/or dispensed from a Hospital or Physician's office.

(27) Mental Disorders

Care, supplies and Treatment of Mental Disorders

(28) Morbid Obesity

Diagnostic testing, surgical procedures, and Prescription Drugs for the Treatment of Morbid Obesity . Surgical Treatment includes, but is not limited to, gastric restrictive procedures and gastric bypass.

(29) Newborn Care

Newborn charges for the following considered as part of the covered mother's claim, provided coverage is in effect:

(a) Hospital nursery charges (facility fee), including room, board, and other normal care for which a Hospital makes a charge, for a healthy newborn child while Confined in a Hospital immediately following birth;

(b) Routine pediatric care for a healthy newborn child while Confined in the Hospital immediately following birth;

(c) Newborn male circumcisions.

Newborn charges are considered part of the covered parent's claim. If the mother is enrolled under this Plan, the mother will be considered the covered parent and the newborn's covered charges will be considered under the mother's claim. If the mother is not enrolled under this Plan, the father will be considered the covered parent and the newborn's covered charges will be considered under the father's plan.

If the baby is ill, suffers an Injury, premature birth, congenital defects, birth abnormalities, or requires care other than routine care, benefits will be provided on the same basis as for any other Illness, provided coverage is in effect.

(30) Occupational Therapy

Occupational Therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Illness, and improve a body function. Covered charges do not include recreational programs, Maintenance Therapy, or supplies used in Occupational Therapy.

(31) Orthotics

The initial purchase, fitting, repair and replacement of orthotic appliances such as braces including orthopedic shoes when integral part of brace, shoe inserts, splints, or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Illness. Shoe inserts are not covered under the Plan.

(32) Outpatient Private Duty Nursing Care

Outpatient Private Duty Nursing Care when Medically Necessary and is not Custodial in nature.

(33) Oxygen

Oxygen and its administration.

(34) Physical Therapy

Physical therapy by a licensed physical therapist. The therapy must be for an Illness or Injury and must be performed to improve a body function. Massage therapy when performed by a licensed physical therapist in connection with covered physical therapy services is also included under this benefit. Covered charges do not include recreational programs or Maintenance Therapy.

(35) Physician's Services

Physician services for an Illness or Injury.

(36) Podiatry / Foot Care

Charges for podiatry will be covered for the following care and Treatment:

(a) Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet, when surgery is performed.

(b) Treatment of toenails, when at least part of the nail root is removed.

(c) Treatment of corns, calluses and toenails, when needed to treat a metabolic or peripheral vascular disease.

(d) Treatment of bunions when an open cutting operation or arthroscopy is performed.

Covered charges do not include Treatment that relieves pain or other symptoms of foot problems when such Treatment does not resolve the underlying Illness (palliative foot care).

(37) Pre-Admission Testing

Diagnostic laboratory tests and x-ray exams for pre-admission testing, including related Physician office visits, when:

(a) Performed on an outpatient basis before a Hospital Confinement;

(b) Related to the condition which causes the Confinement; and

(c) Performed in place of tests while Hospital Confined.

Charges for this testing are allowed even if tests show the condition requires medical Treatment prior to Hospital Confinement or the Hospital Confinement is not required.

(38) Prescription Drugs

Outpatient Prescription Drugs, other than drugs administered directly by a covered provider, are not covered under the Medical Benefits section of this booklet unless specifically listed as a covered charges.

Refer to the Prescription Drug Benefits section of this Plan for further details regarding Prescription Drug coverage.

(39) Prosthetics

The initial purchase, fitting, repair and replacement of fitted prosthetic devices, which replace body parts. Covered charges do not include repair or replacement of prosthetic devices.

(40) Reconstructive Surgery

Correction of abnormal congenital conditions, repair of damage from an accident or Injury, and reconstructive mammoplasties will be considered covered charges.

In a manner determined in consultation with the attending Physician and the patient, reconstructive mammoplasty coverage will include reimbursement for:

(a) Reconstruction of the breast on which a mastectomy has been performed,

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(c) Coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas.

(41) Second or Third Surgical Opinion

A second opinion consultation to determine the Medical Necessity of a non-Medical Emergency surgical procedure.

The Covered Person may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

(42) Skilled Nursing Facility – Inpatient Services

The room and board, nursing care, and supplies furnished by a Skilled Nursing Facility if and when:

(a) The patient is Confined as a bed patient in the facility;

(b) The attending Physician certifies that the Confinement is needed for further care of the condition that caused the Hospital Confinement; and

(c) The attending Physician completes a treatment plan, which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the Skilled Nursing Facility.

(43) Sleep Disorders

Diagnostic services, surgical procedures, non-surgical procedures, and Prescription Drugs for the Treatment of obstructive sleep apnea only.

(44) Speech Therapy

Speech therapy by a licensed speech therapist. Therapy must be ordered by a Physician and either:

(a) follows surgery for correction of a Congenital Anomaly of the oral cavity, throat or nasal complex (other than a frenectomy);

(b) follows an Injury; or

(c) follows an Illness that is other than a learning or Mental Disorder;

Covered charges do not include Maintenance Therapy.

(45) Substance Abuse Treatment

Care, supplies and Treatment of Substance Abuse.

Covered charges also include Treatment for detoxification from chemical substances and are limited to physical detoxification when necessary to protect a Covered Person's health and well being.

(46) Supplementary Accident Benefits

This benefit applies when a Covered Person receives care and Treatment of an accidental Injury and:

(a) The Injury is sustained while the Covered Person is covered for these benefits; and

(b) To the extent that the charge is not payable under any other benefits under this Plan (other than Medical Benefits).

Eligible accident expenses include the following:

(a) Physician services

(b) Hospital care and Treatment

(c) Diagnostic x-rays and lab tests

(d) Local professional ambulance service

(e) Surgical dressings, splints and casts and other devices used in the reduction of fractures and dislocations

(f) Nursing service

(g) Anesthesia

(h) Covered Prescription Drugs

(i) Use of a Physician’s office or clinic operating room

The maximum amount payable for the total of all covered charges incurred as the result of one accident will not exceed the dollar limit shown in the Schedule of Benefits.

Covered charges incurred in excess of the maximum amount will be considered under the benefits otherwise provided by this Plan.

(47) Surgery

Surgery performed by a Physician and services of an assistant surgeon, when required.

Charges for multiple surgical procedures will be a covered subject to the following provisions:

(a) The negotiated rate will be used for PPO providers and the Usual and Reasonable Charge will be used for Non-PPO providers.

(b) If bilateral or multiple surgical procedures are performed by one surgeon, 50% of the primary procedure will be allowed for each additional procedure performed through the same incision; and 50% will be allowed for each additional procedure performed through a separate incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(c) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the allowed charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the allowed charge for that procedure; and

(d) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's allowance.

(48) Surgical Supplies

Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.

(49) Temporomandibular Joint (TMJ) Syndrome

Diagnostic services, surgical procedures, and non-surgical procedures for the Treatment of Temporomandibular Joint (TMJ) Syndrome.

(50) Urgent Care Facility

Services and supplies furnished by an Urgent Care Facility.

(51) Vision Exams

Charges for vision exams, as shown in the Schedule of Benefits. Coverage does not include vision materials, frames, lenses, contact lenses and laser eye surgery.

(52) Well Care

Routine well care services and supplies. Routine well care means care by a Physician that is not for an Injury or Illness.

(53) Well Child Care

Routine well child care services and supplies. Routine well child care means routine pediatric care by a Physician that is not for an Injury or Illness.

(54) Wigs

Charges associated with the initial purchase of a wig after chemotherapy.

ORGAN AND TISSUE TRANSPLANT PROVISIONS

Eligible expenses for approved transplant services incurred in connection with an organ or tissue transplant will be covered subject to pre-authorization by this Plan's Medical Management service. Transplant coverage is provided for approved transplant services obtained from an URN Transplant Facility through United Resource Networks (URN) a preferred provider network of specialized professionals and facilities. Coverage is also provided for approved transplant services obtained outside an URN Transplant Facility at a reduced benefit level.

Benefit levels are listed in the Schedule of Benefits under Organ Transplant.

Approved Transplant Services

Approved transplant services are Covered Health Services and supplies provided at an URN Transplant Facility or a Non-URN Transplant Facility during the benefit period which are related to transplantation and approved in writing by this Plan prior to the delivery of any services. Such services include, but are not limited to, Hospital charges, Physician charges, ancillary services, and Prescription Drugs rendered during a benefit period for the following transplants:

Heart	Liver
Kidney/Pancreas	Lung
Kidney	Allogeneic Bone Marrow
Pancreas	Autologous Bone Marrow
Heart/Lung	Peripheral Blood Stem Cell
Intestinal	Intestinal/Liver

Notification Requirements for Payment of Plan Benefits

Written authorization for all transplant related services must be obtained from the Medical Management service prior to the initial evaluation. All transplant procedures must be coordinated with the Medical Management service designated by this Plan before the Covered Person has received any services, including an initial evaluation. It is the Covered Person's responsibility to obtain such authorization. **Failure to obtain prior authorization will result in the exclusion of such expenses under this Plan.**

As a result of the pre-authorization review, the Covered Person will be asked to consider obtaining transplant services at URN Transplant Facility. URN's goal is to provide access to necessary transplants in the most appropriate setting for the procedure with consideration of an enhancement of the quality of patient care.

There is no obligation for the Covered Person to use URN Transplant Facility. However, benefits for the transplant and its related expenses will vary depending upon whether services are provided in or out of an URN Transplant Facility.

Initial Evaluation

An initial evaluation is the earliest of any testing, laboratory blood work, diagnostic testing, HLA typing, donor identification, harvesting and storage of bone marrow, therapeutic services, inpatient or outpatient health care services, surgical services, and any services rendered by health care professionals in association with an evaluation for transplantation, regardless of the site of service.

Second Opinion Policy

If a second opinion is required at any time during the evaluation period, the Transplant Case Manager will be responsible for notifying the potential transplant candidates. The Covered Person may contact the Medical Management service to be referred to a second URN Transplant Facility for another evaluation.

Benefit Period for Approved Transplant Services

The benefit period is the period of time from the date the Covered Person receives an Initial Evaluation for the transplant procedure until the earliest of (1) one year from the date the transplant procedure was actually performed; or (2) the date a Covered Person's coverage terminates under this Plan.

Organ/Tissue Acquisition-Donor Expenses

Medical expenses of the donor will be covered only if:

(1) The recipient is covered under this Plan; and

(2) The donor is covered under this Plan; and

(3) The transplant is performed at an URN Transplant Facility.

Eligible Expenses for Approved Transplant Services

The term 'eligible expenses' with respect to transplants includes Usual and Reasonable expenses incurred by a Covered Person for services and supplies which are appropriate for the transplant procedure, including:

(1) Initial evaluation, screening and candidacy determination process.

(2) Organ/tissue acquisition, including donor expenses not eligible under the donor's plan of benefits, which consist of:

- **(a)** Organ procurement from a non-living donor including removing, preserving and harvesting the organ.
- **(b)** Organ procurement from a living donor including screening the potential donor, transporting the donor to and from the site of the transplant, as well as the medical expenses associated with removal of the donated organ, medical services provided to the donor in the interim, and for follow-up care.
- **(c)** Expenses for a bone marrow transplant, including the cost involved in the removal of the Covered Person's bone marrow (autologous) or donated marrow (allogeneic), search expenses to identify an unrelated match, and Treatment and storage costs of the marrow, up to the time of reinfusion. The harvesting of the marrow need not be performed within the transplant benefit period.

(3) Organ/Tissue transplantation including:

- **(a)** All inpatient room and board and ancillary expenses;
- **(b)** Nursing expenses;
- **(c)** Inpatient drugs;
- **(d)** Outpatient expenses by the facility; and
- **(e)** Professional services.

(4) Follow-up care, including immunosuppressant therapy.

(5) Re-transplantation expenses for one re-transplant, for a total of two transplants per Covered Person, per Lifetime while covered under this Plan. If a re-transplant is necessary, a new benefit period will begin at the time of initial evaluation for that transplant.

Accumulation of Expenses

Expenses incurred for the Covered Person and for the donor will accumulate toward the Covered Person's benefit and will be included in this Plan's over-all per-person Lifetime Maximum Benefit.

Travel Expenses:

When approved transplant services are performed at an URN Transplant Facility, this Plan will provide coverage for travel, lodging and meals as follows:

(1) Transportation for the Covered Person and one companion to accompany the Covered Person to and from an URN Transplant Facility. If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered.

(2) Reasonable and necessary expenses for lodging and meals for the Covered Person (while not Confined) and one companion (two companions for a covered dependent minor child) who accompanied the Covered Person.

(3) Travel and lodging expenses are covered only if the transplant recipient resides more than 50 miles from the URN Transplant Facility.

LIMITATION AND EXCLUSIONS

Limitation

A Covered Person is eligible for coverage under this Plan for up to two transplants per Lifetime. Multiple organ/tissue transplants performed at the same time such as heart/lung are considered to be one transplant.

Exclusions

No benefits are allowable under the Organ/Tissue Transplant Schedule of Benefits for:

(1) Expenses which exceed the Usual and Reasonable expenses for Non-URN.

(2) Organ/tissue acquisition and donor expenses when the transplant is performed at a Non-URN Transplant Facility;

(3) Animal to human transplant procedures;

(4) Artificial or mechanical devices designed to replace human organs;

(5) Expenses beyond the Lifetime maximum benefit;

(6) Expenses Which are otherwise excluded by this Plan;

(7) Organ/tissue transplants which are not listed as Approved Transplant Services;

(8) Transplants considered Experimental, Investigational or Unproven Services;

(9) Expenses incurred for services required to meet the patient selection criteria for the approved transplant procedure including, but not limited to, programs such as chemical dependency, detoxification and rehabilitation services, Treatment of nicotine or caffeine addiction, services and related expenses for weight loss programs, nutritional supplements, appetite suppressants and supplies of a similar nature otherwise not covered under the Organ/Tissue Transplant Provisions of this Plan. Refer to Medical Benefits and Plan Exclusions for additional benefit information regarding these services;

(10) Expenses incurred for or in connection with any of the following:

- Allogeneic Bone Marrow Transplant, Autologous Bone Marrow Transplant, or Peripheral Blood Stem Cell Transplant for:
  - Lung cancers; or
  - Melanomas; or
  - Colon cancers; or
  - AIDS.
- Solid organ transplantation, Allogeneic Bone Marrow Transplant, Autologous Bone Marrow Transplant, and Peripheral Blood Stem Cell Transplant for conditions that are not considered to be appropriate, according to this Plan's guidelines for transplantation; and solid organ transplant in patients with carcinoma.

PLAN EXCLUSIONS

Note: *All exclusions related to Prescription Drugs are shown in the Prescription Drug Benefits section.*

For all Medical Benefits, including those shown in the Schedule of Benefits, the following are not covered by this Plan:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy.

(2) **Alternative Treatment.** Acupressure, acupuncture, massage therapy, rolfing, aroma therapy, hypnotism, and other forms of alternative Treatment as defined by the Office of Alternative Medicine of the National Institutes of Health, except as otherwise specified as covered.

(3) **Biofeedback therapy.**

(4) **Circumcisions.** Circumcisions other than those for a newborn male.

(5) **Complications of non-covered Treatments.** Care, services or Treatment required as a result of complications from a Treatment not covered under this Plan, except for charges incurred for complications from a non-covered abortion.

(6) **Cosmetic procedures.** Care and Treatment provided for cosmetic reasons, including but not limited to pharmacological regimens; nutritional procedures or Treatments; plastic surgery; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal or revision of scars, tattoos, actinic changes, and/or which are performed as a Treatment for acne. This exclusion will not apply if the care and Treatment is for repair of damage from an accident or is for correction of abnormal congenital condition in a child.

See the Reconstructive Surgery benefit in the Medical Benefits section of this document for information regarding coverage of reconstructive mammoplasty.

(7) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(8) **Educational or vocational testing.** Services for educational or vocational testing or training.

(9) **Excess charges.** The part of an expense for care and Treatment of an Injury or Illness that is in excess of the Usual and Reasonable Charge.

(10) **Exercise programs.** Exercise programs for Treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational, or physical therapy covered by this Plan.

(11) **Experimental, Investigational or Unproven or not Medically Necessary.** Care and Treatment that is either Experimental, Investigational, Unproven, or not Medically Necessary, as defined by this Plan.

(12) **Eye care.** Eye exercise therapy, radial keratotomy, or other eye surgery to correct near-sightedness, or frames and frame-type lenses This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or routine eye exams (including refractions).

(13) **Government coverage.** Care, Treatment, or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(14) **Hair loss.** Care and Treatment for hair loss, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician.

(15) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting. Routine hearing exams are not covered under this Plan.

(16) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(17) **Illegal acts.** Charges for services received as a result of Injury caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.

(18) **Impotence.** Diagnostic services, surgical and non-surgical procedures, and Prescription Drugs in connection with Treatment of impotence.

(19) **Infertility.** Diagnostic testing, surgical procedures, surgical impregnation (i.e., in-vitro fertilization, artificial insemination) and Prescription Drugs in connection with Treatment of infertility.

(20) **Naturopathy.** Services provided in connection with naturopathy.

(21) **No charge.** Care and Treatment for which there would not have been a charge if no coverage had been in force.

(22) **Non-emergency Hospital admissions.** Care and Treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(23) **Non-Morbid Obesity.** Care and treatment of non-morbid obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness. Charges for Morbid Obesity are covered as specified in this Plan.

(24) **No obligation to pay.** Charges incurred for which this Plan has no legal obligation to pay.

(25) **No Physician recommendation.** Care, Treatment, services or supplies not recommended and approved by a Physician; or Treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or Treatment, which is appropriate care for the Injury or Illness.

(26) **Not specified as covered.** Services, Treatments, and supplies which are not specified as covered under this Plan.

(27) **Nutritional services.** Nutritional counseling and services provided by a nutritionist.

(28) **Occupational.** Care and Treatment of an Injury or Illness that, in either case, is occupational – that is, arises from work for wage or profit, including self-employment, or is covered under any Workers' Compensation law.

(29) **Outpatient prescribed or non-prescribed medical supplies**. Outpatient prescribed or non-prescribed medical supplies including, but not limited to, over-the-counter drugs and Treatments, elastic stockings, Ace bandages, gauze, syringes, diabetic test strips, ostomy supplies, and similar supplies. Tubings and masks are excluded except as integral use of Durable Medical Equipment.

(30) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-Prescription Drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

(31) **Plan design excludes.** Charges excluded by this Plan design as mentioned in this document.

(32) **Podiatry/Foot care.** Charges for Treatment that relieves pain or other symptoms of foot problems when such Treatment does not resolve the underlying Illness (palliative foot care).

(33) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(34) **Replacement orthotic braces.** Replacement of orthotic braces of the leg, arm, back, neck, or artificial arms or legs or replacement of prosthetic devices

(35) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury, while sane or insane. This exclusion will not apply if the Injury resulted from a medical condition (such as depression).

(36) **Services before or after coverage.** Care, Treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(37) **Sex changes.** Care, services or Treatment for non-congenital transsexualism, gender dysphoria, or sexual reassignment or change. This exclusion includes Prescription Drugs, implants, hormone therapy, medical or psychiatric Treatment or surgery.

(38) **Sleep disorders.** Care and treatment for sleep disorders, except obstructive sleep apnea.

(39) **Smoking cessation.** Care and Treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.

(40) **Sports-related safety/performance devices and programs.** Devices used specifically as safety items or to affect performance primarily in sports-related activities. All charges related to physical conditioning programs, such as athletic training, body-building, exercise, fitness flexibility and diversion, or general motivation.

(41) **Sterilization/Surgical sterilization reversal.** Care and Treatment for sterilization and reversal of surgical sterilization.

(42) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician. This exclusion does not apply to eligible ambulance charges and travel or accommodations charges incurred as a result of a covered organ or tissue transplant that is defined as a covered expense.

(43) **War.** Any loss that is due to a declared or undeclared act of war.

(44) **Well Care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or Treatment or services not directly related to the diagnosis or Treatment of a specific Injury, Illness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically listed as covered in the Schedule of Benefits.

(45) **Wig.** Charges associated with the purchase of a wig except those associated with the initial purchase of a wig after chemotherapy.

PRESCRIPTION DRUG BENEFITS

PHARMACY DRUG CHARGE

Participating pharmacies have contracted with this Plan to charge Covered Persons reduced fees for
Participating pharmacies have contracted with this Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Innoviant is the administrator of the Pharmacy drug plan.

The Plan will pay for covered charges incurred for the dispensing of Prescription Drugs. The Plan will pay for the benefits at the Contracted Amount described below minus the copayment as shown in the Prescription Drug Benefits Schedule.

Benefits will not be paid for Prescription Drugs purchased before coverage with this Plan begins or after coverage under this Plan or this provision terminates.

Copayment. The copayment is applied to each covered Prescription Drug charge and is shown in the Prescription Drug Benefits Schedule. Any one Prescription is limited to a 34-day supply. The Prescription copayment cannot be used to satisfy the Plan deductible amount or out-of-pocket expense maximum and is not a covered charge under the Medical Plan.

Non-Participating Pharmacy. Using a Non-Participating Pharmacy will require a cash payment and submission of completed reimbursement form with a receipt to Innoviant for reimbursement. Reimbursement for covered Prescription Drugs will be determined by the lowest contracted rate of a participating Pharmacy.

MAIL ORDER DRUG BENEFIT OPTION

The Plan will pay for covered charges incurred by a Covered Person for Prescription products dispensed through the mail order Pharmacy identified by the Pharmacy Benefit Administrator. Prescription products may be ordered by mail with a copayment from the Covered Person for each Prescription or refill. The mail order drug benefit option is available for maintenance Medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). By law, Prescription Drugs cannot be mailed into, or outside of, the United States.

Copayment. The copayment is applied to each covered mail order Prescription charge and is shown in the Prescription Drug Benefits Schedule. Any one Prescription is limited to a 90-day supply. The Prescription copayment cannot be used to satisfy the Plan deductible amount or out-of-pocket expense maximum and is not a covered charge under the Medical Plan.

LIMITS TO THIS BENEFIT

When a Covered Person incurs a 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.

COVERED BENEFITS

Prescription products which are:

(1) Necessary for the care and Treatment of an Illness or Injury and are prescribed by a duly licensed Prescriber; and

(2) Can be obtained only by Prescription and are dispensed from a container labeled “Rx only”.

(3) The following Non-Prescription products prescribed by a duly licensed Prescriber:

(a) Compounded Medications of which at least one ingredient is a Prescription Drug; and

(b) Any other Medications which due to state law may only be dispensed when prescribed by a duly licensed Prescriber; and

(c) Non-Prescription, (over-the-counter) products determined by the Pharmacy and Therapeutics Committee to be appropriate for coverage when accompanied by a Prescription; and

(d) In an amount not to exceed the days supply outlined in the Prescription Drug Benefits Schedule.

(4) The following diabetic supplies:

Lancets, alcohol swabs, reaction treating tablets, blood glucose monitor, urine test strips, blood test strips, insulin, insulin syringes and needles and anti-diabetic products at standard plan benefits.

Note: *Roche Diagnostics AccuChek® glucometers are available to members at no charge. Contact the Innoviant customer service center for details.*

(5) Non-combination Prescription requiring products containing vitamins A, D, E or K.

(6) Prescription prenatal vitamins.

PRESCRIPTION DRUG EXCLUSIONS

The following are not covered by this Plan:

(1) Charges which are in excess of the Contracted Amount.

(2) Therapeutic devices or appliances, including hypodermic needles, syringes (except as stated above), support garments, and other non-medical substances, without regard to their intended use.

(3) Immunization agents, biological sera, blood, or blood plasma.

(4) Products labeled: "Caution-limited by federal law to Investigational use", or Experimental drugs even though a charge is made to the Covered Person. Approved Prescription products prescribed for Investigational or Experimental purposes or in Investigational or Experimental dosages.

(5) Any charge for the administration of Prescription products.

(6) Any Medication which is meant to be taken by or administered to the Covered Person, in whole or in part, while the Covered Person is treated at a Hospital, a Physician’s office or extended care facility (but is instead self-administered or administered elsewhere), unless expressly designated by the Pharmacy Benefits Administrator.

(7) Refilling a Prescription in excess of the number specified on the Prescription or any refill dispensed after one year from the order of the Prescriber.

(8) Prescription products which are not dispensed by a licensed pharmacist or Prescriber.

(9) Prescription products which may be received without charge under local, state or federal programs, including Worker's Compensation.

(10) Approved Prescription products with no approved Food and Drug Administration (FDA) indications for the purpose for which prescribed.

(11) Replacement Prescription products resulting from loss, theft, or damage.

(12) Prescription products available over-the-counter that do not require a Prescription order by federal or state law and any Medication that is equivalent to an over-the-counter Medication unless the product is a Non-Prescription (or over-the-counter) product determined by the Pharmacy and Therapeutics Committee to be appropriate for coverage when accompanied by a Prescription.

(13) Contraceptive products, including oral tablets, patches and self-insertable vaginal devices containing contraceptive hormones, regardless of the purpose.

(14) Prescription smoking deterrent products.

(15) Anorectics or any other products used for the purpose of weight control.

(16) Prescription topical acne products for a Covered Person, unless determined Medically Necessary by the Pharmacy Benefits Administrator.

(17) Any other cosmetic hair growth prescription products.

(18) Oral Medications for cosmetic management of onychomycosis, unless determined Medically Necessary by the Pharmacy Benefits Administrator.

(19) Prescriptions that are cosmetic in nature, unless the Prescription is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal Injury resulting from an accident or trauma, or disfiguring disease.

(20) Prescription products used to enhance sexual function or satisfaction.

(21) Prescriptions and Prescription refills that exceed the Pharmacy Benefit Administrator's Quantity Limits.

(22) Infertility product.

(23) Prescription products, if prior authorization was needed but not requested; and Prescription products, if prior authorization was requested but denied.

(24) Growth hormone products, unless determined Medically Necessary by the Pharmacy Benefits Administrator.

(25) Anabolic steroids.

(26) All illegal Medications or supplies even if prescribed by a duly licensed Prescriber.

(27) The difference in cost between a Generic Product and Brand Name Product when the Prescriber has not written a Brand Name Product or has not indicated that the Brand is necessary.

If requested Medication or supply is not covered, in whole or in part, the Covered Person still has a right to purchase that product, however the entire cost of the product will be their responsibility.

PRIOR-AUTHORIZATION INFORMATION FOR PRESCRIPTION MEDICATIONS

If the Prescriber believes that a Covered Person needs a Prescription Medication that is on the Prior Authorization List, or is not covered for other reasons, the Prescriber can contact the Pharmacy Benefits Administrator to request the Plan Administrator's review of the situation. The Prescriber will give the Pharmacy Benefits Administrator required information on the Covered Person's medical condition so the Plan Administrator can properly evaluate the need for the requested Medication.

Upon review by a licensed pharmacist, the Pharmacy Benefits Administrator may do one of the following:

- Approve the Prescribers request and authorize coverage of this Medication for a certain period of time at the appropriate copayment.
- Recommend an alternate Medication for consideration by the Prescriber.
- Deny the request to cover the requested Medication.

If the Prescription Medication requires prior authorization but the Covered Person cannot wait for the prior authorization review to take place, they can ask the Prescriber if a drug sample is available, or the Pharmacy may provide a short-term supply (such as a 5-day supply) while the prior authorization review is taking place. The Covered Person will be responsible for the full cash copayment at this time. This copayment will not be credited toward this Prescription if dispensed on a later date.

REVIEW OF MEDICATIONS AND SUPPLIES BY THE PHARMACY AND THERAPEUTICS COMMITTEE

The Pharmacy and Therapeutics Committee may, in its professional judgment modify Medications and supplies on the Preferred Products List as follows:

- Place products on the Preferred Products List and remove products from the Preferred Products List.

- Place certain products on the Prior Authorization List and remove products from the Prior Authorization List.

- Categorize certain Non-Prescription products (over-the-counter products)

Actions by the Pharmacy and Therapeutics Committee take place quarterly, as medical technology evolves, as indications, or Food and Drug Administration (FDA) guidelines change.

The Pharmacy Benefits Administrator will inform the Covered Persons of the actions taken by the Pharmacy and Therapeutics Committee as appropriate, including when benefits are affected.

APPEAL PROCEDURES

Send Pharmacy appeals within 180 days of the date of the claim to:

Innoviant
PO Box 8082
Wausau, WI 54402-8082

A claim appeal can be filed by the Covered Person or, if a minor dependent, the parent or Legal Guardian of the dependent.

After reviewing a claim that has been appealed, the Pharmacy Benefits Administrator will notify the Covered Person of its decision within a reasonable period of time but no later than 30 calendar days after the Pharmacy Benefits Administrator receives the request for review for the first appeal, and another 30 calendar days for the second appeal, or a maximum of 60 calendar days for the two appeal levels.

FOR MORE INFORMATION ON PHARMACY BENEFITS:

If a Covered Person needs more information on products or services available or they have any questions about Prescription Benefits, they can call the Pharmacy Benefits Administrator, Innoviant, at 877-559-2955, Monday through Friday, from 7:00 a.m. to 7:00 p.m. central standard time, or go to the Web site at www.innoviant.com.

HOW TO SUBMIT A CLAIM

When a Covered Person has a claim to submit for benefit consideration that person must:

(1) Obtain a claim form from the Human Resources Department or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician or Dentist complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Group number of Plan
- Employee's name
- Employee's Identification (I.D.) Number
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the address shown on the back of the Covered Person's Identification Card.

WHEN CLAIMS SHOULD BE FILED

All claims should be submitted within 12 months of the date charges are incurred. A charge will be deemed incurred on the date services are actually rendered or supplies are actually received. Claims filed later than 12 months from the date of service will be declined unless the Covered Person was legally incapacitated.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIM PAYMENT

All Payments will be issued directly to the provider of the service unless receipted bills showing payment has been made are submitted. In the event of the Covered Person's death, direct Payment will continue to be made to the provider.

CLAIM PROCEDURES

DEFINITIONS

The following claim definitions have special meaning when used in this Plan in accordance with Claim Procedures.

A **"Claim"** is any request for a Plan benefit or benefits made by a Covered Person or by an authorized representative of the Covered Person in accordance with the Plan's procedures for filing benefit claims.

An **"Urgent Care Claim"** is a claim for medical care to which applying the time periods for making pre-service claims decisions could seriously jeopardize the claimant's life, health or ability to regain maximum function or would subject the claimant to severe pain that cannot be adequately managed without the care that is the subject of the claim. If the treating Physician determines the claim is "urgent," the Plan must treat the claim as urgent.

A **"Pre-Service Claim"** is a request for approval of a benefit in which the terms of the Plan condition the receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. Examples of a Pre-Service Claim include but are not limited to a prior authorization of general items or health services (i.e., dental authorizations, Hospital pre-certification).

A **"Post-Service Claim"** is a claim that under this Plan is not a Pre-Service Claim (i.e., a claim that involves consideration of Payment or reimbursement of costs for medical care that has already been provided).

Requests for determinations of eligibility or general inquiries to the availability of particular Plan benefits or the circumstances under which benefits might be paid under the terms of the Plan will not be treated as a claim for benefits for the purposes of the Claim Procedures.

INITIAL CLAIM DETERMINATIONS

Provided a Covered Person files a claim for benefits in accordance with the terms of the Plan specific to each type of claim, the Plan will make an initial claim determination and inform you:

(1) Within 72 hours after receipt of an Urgent Care Claim by the Plan. This notice, whether adverse or not, must be provided to you in writing within 3 days of any oral communication;

(2) Within 15 calendar days after receipt of a Pre-Service Claim by the Plan. This notice, whether adverse or not, must be provided in writing;

(3) Within 30 calendar days after receipt of a Post-Service Claim by the Plan;

The time periods above are considered to commence upon the Plan's receipt of a claim for benefits filed in accordance with the terms of the Plan specific to each type of claim, without regard to whether all of the information necessary to decide the claim accompanies the filing.

If a claim is wholly or partially denied, the Plan will furnish the Covered Person with a written notice of the denial. The written notice will contain the following information:

(1) The specific reason(s) for the denial and reference to the specific Plan provisions on which the denial is based. If a protocol was followed, then the notice will state that a protocol was relied upon and that a copy of such protocol is available to the Covered Person free of charge upon request. If the claim was denied because it does not meet the definition of Medically Necessary or is experimental in nature, or if denial is due to a similar exclusion or limit, then the notice will state that an explanation of the scientific or clinical judgment used in applying the terms of the Plan to the Covered Person's medical circumstances can be provided free of charge to the Covered Person upon request;

(2) A description of any additional information or material necessary to perfect the claim and an explanation of why such material or information is necessary; and

(3) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Covered Person's right to bring a civil action under section 502(a) of ERISA following an appeal of that claim denial.

If the denied claim is an Urgent Care Claim, the notice will also contain a description of the expedited review process applicable to such claims. Notification of a denied Urgent Care Claim may be made orally, provided that (a) notification is made within 72 hours after receipt of claim by the Plan, and (b) written or electronic notification is furnished to the Covered Person no later than 3 days after receipt of oral notification.

Concurrent Care Decisions. Any decision by the Plan to terminate or reduce benefits that have already been granted with the potential of causing disruption to ongoing care, course of treatment, number of Treatments or Treatments provided as Medically Necessary before the end of such Treatments shall constitute a denied claim. The Plan will provide a Covered Person with notice of the denial at a time sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review before the benefit is reduced or terminated. The written notice of denial will contain the information outlined above.

Any Urgent Care Claim requesting to extend a course of treatment beyond the initially prescribed period of time, or number of Treatments, must be decided within 24 hours provided that the claim is made at least 24 hours prior to the expiration of the initially prescribed period. Notification will be provided in accordance with the Urgent Care Claim notice requirements outlined above.

Incomplete Urgent Care Claims Notification. In the case of an Urgent Care Claim, if additional information is required to make a claim determination, the Plan will provide the Covered Person notification that will include a description of the information needed to complete the claim. This notice must be provided within 24 hours after receipt of the claim. The Covered Person shall be afforded at least 48 hours from receipt of the notice in which to provide the specified information. The Plan shall make its initial determination as soon as possible, but in no case later than 48 hours after the earlier of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the Covered Person to provide the specified additional information.

Extensions of Time. The Plan may extend decision-making on both Pre-Service Claims and Post-Service Claims for one additional period of 15 days (30 days plus an additional 30 days for disability claims) after expiration of the relevant initial period, provided the Plan Administrator determines that an extension is necessary for reasons beyond control and the Plan notifies the Covered Person prior to the expiration of the relevant initial period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the notice of extension is provided, a Covered Person shall be afforded at least 45 days from receipt of the notice to respond. There is no extension permitted in the case of Urgent Care Claims.

Required Filing Procedures for Pre-Service Claims. In the event a Covered Person or authorized representative of the Covered Person does not follow the Plan's claim filing procedures for a Pre-Service Claim, the Plan will provide notification to the Covered Person or authorized representative accordingly. For all Pre-Service Claims, the Plan must notify the Covered Person or authorized representative, of failure to follow filing procedures within 5 calendar days (24 hours in the case of a failure to follow filing procedures for an Urgent Care Claim). Notification by the Plan may be oral unless written notification is requested by the Covered Person or authorized representative. The notification of failure to follow filing procedures for Pre-Service Claims will apply only when a communication is received from a Covered Person or health care professional representing the Covered Person that specifies the identity of the Covered Person, a specific medical condition or symptom, and a specific Treatment, service or product for which approval is requested, and the communication is received by the Claims Administrator.

APPEAL PROCESS

In cases where a claim for benefits Payment is denied in whole or in part, the Covered Person may appeal the denial. This appeal provision will allow the Covered Person to:

(1) Request from the Plan a review of any claim for benefits. Such request must include:

(a) Employee name

(b) Covered Employee's Social Security Number

(c) Name of the patient and,

(d) Group Identification, if any

(2) Request for review must be in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

(3) Submit written comments, documents, records, and other information relating to the claim.

(4) Request, free of charge, reasonable access to documents, records, and other information relevant to the Covered Person's claim. A document, record or other information is considered relevant if it was relied on in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination; demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied Treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The request for review must be directed to the Plan Administrator within 180 days after the claim Payment date or the date of the notification of denial of benefits. In the case of Urgent Care Claims, a request for an expedited review may be submitted orally and all necessary information, including the Plan's benefit determination upon review, may be transmitted between the Plan and Covered Person via telephone, facsimile, or other available similarly expeditious methods.

The review of the denial will be made by the Plan Administrator, or by an appropriate named fiduciary who is neither the party who made the initial claim determination nor the subordinate of such party. The review will not defer to the initial claim determination and will take into account all comments, documents, records and other information submitted by the Covered Person without regard to whether such information was previously submitted or relied upon in the initial determination. In deciding an appeal of any denied claim that is based in whole or in part on a medical judgment, the Plan must consult with an appropriately qualified health care professional who is neither an individual who was consulted in connection with the denied claim that is the subject of the appeal nor the subordinate of any such individual.

The Plan Administrator will provide the Covered Person with a written response:

(1) Within 72 hours after receipt of the Covered Person's request for review in the case of Urgent Care Claims;

(2) Within 30 calendar days after receipt of the Covered Person's request for review in the case of Pre-Service Claims;

(3) Within 60 calendar days after receipt of the Covered Person's request for review in the case of Post-Service Claims;

If a claim on review is wholly or partially denied, the written notice will contain the following information:

(1) The specific reason(s) for the denial and reference to the specific Plan provisions on which the denial is based. If a protocol was followed in making the determination, then the notice will state that a protocol was relied upon and that a copy of such protocol is available to the Covered Person free of charge upon request. If the claim was denied because it does not meet the definition of Medically Necessary or is experimental in nature, or if denial is due to a similar exclusion or limit, then the notice will state that an explanation of the scientific or clinical judgment used in applying the terms of the Plan to the Covered Person's medical circumstances can be provided free of charge to the Covered Person upon request, including the names of any medical professionals consulted during the review process.

(2) A statement that the Covered Person is entitled to request, free of charge, reasonable access to all documents, records, and other information relevant to the Covered Person's claim.

(3) A statement of the Covered Person's right to bring a civil action under section 502(a) of ERISA.

(4) A statement notifying the Covered Person about potential alternative dispute resolution methods, if any.

If the Covered Person feels the Plan has not complied with the established Plan Claim Procedures, there are steps the Covered Person can take to enforce their rights. For additional information, refer to the ***EMPLOYEE RIGHTS UNDER ERISA*** subsection of the ***RESPONSIBILITIES FOR PLAN ADMINISTRATION*** section in this **PLAN DOCUMENT**.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of covered charges when two or more plans - including Medicare - are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's spouse is covered by this Plan and by another plan or the couple's covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

Carve-Out. The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will calculate the benefit up to each plan's benefit level as if there were no other plan involved. If the calculated benefit under the secondary (or subsequent) plan exceeds the benefit paid by the primary plan, the secondary (or subsequent) plan will pay the difference between what the primary carrier actually paid and the benefit calculated by the secondary or subsequent plans. If the normal benefit under the secondary (or subsequent) plan is less than the benefit paid by the primary plan, no further payment will be issued. The total reimbursement will never be more than the secondary (or subsequent) plan's benefit level - 50% or 80% or 100% - whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Group practice and other group prepayment plans.

(3) Federal government plans or programs. This includes Medicare.

(4) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(5) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be considered a covered expense under this Plan. In addition, any portion of the charges that exceeds the Usual and Reasonable Charge, as defined by this Plan, or the PPO negotiated rate (if applicable) is not considered an allowable charge under this provision.

In the case of HMO (Health Maintenance Organization) plans: This Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Also, when an HMO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile Limitations. When medical payments are available under vehicle insurance, this Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits by the following rules, up to the allowable charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) (Plan A) are determined before those of the plan which covers the person as a dependent (Plan B).

Special Rule. If: (i) the person covered directly is a Medicare beneficiary, (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay before Plan A.

(b) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a SELF-PAY CONTINUATION OF COVERAGE beneficiary.

(d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims Determination Period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

OTHER PARTY RECOVERY PROVISION

Reimbursement

This section applies when a Covered Person, or the legal representative, estate or heirs of the Covered Person (sometimes collectively referred to as the "Covered Person") recovers damages, by settlement, verdict or otherwise, for an Injury, Illness or other condition. If the Covered Person has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an Injury or Illness or the Treatment of such an Injury or Illness. These benefits are specifically excluded.

However, if the Plan does advance moneys or provide care for such an Injury, Illness or other condition, the Covered Person shall promptly convey moneys or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by the Covered Person (or by the legal representatives, estate or heirs of the Covered Person), to the Plan for the reasonable value of the medical benefits advanced or provided by the Plan to the Covered Person, regardless of whether or not (1) the Covered Person has been fully compensated, or "made-whole" for his/her loss; (2) liability for payment is admitted by the Covered Person or any other party; or (3) the recovery by the Covered Person is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over the Covered Person, or any other party, to receive reimbursement of the benefits advanced on the Covered Person's behalf. This reimbursement shall be from any recovery made by the Covered Person, and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties.

In order to secure the rights of the Plan under this section, and because of the Plan's advancement of benefits, the Covered Person hereby (1) acknowledges that the Plan shall have first priority against the proceeds of any such settlement, arbitration award, verdict, or any other amounts received by the Covered Person; and (2) assigns to the Plan any benefits the Covered Person may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. The Covered Person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan under this section, the Covered Person acknowledges that any proceeds of settlement or judgment, including a Covered Person's claim to such proceeds held by another person, held by the Covered Person or by another, are being held for the benefit of the Plan under these provisions.

The Covered Person shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided. The Covered Person shall not take any action that prejudices the Plan's rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this section, and/or to set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of Covered Person, whether under comparative negligence or otherwise.

Subrogation

This section applies when another party is, or may be considered, liable for a Covered Person's Injury, Illness or other condition (including insurance carriers who are so financially liable) and the Plan has advanced benefits.

In consideration for the advancement of benefits, the Plan is subrogated to all of the rights of the Covered Person against any party liable for the Covered Person's Injury or Illness, or is or may be liable for the payment for the medical Treatment of such Injury or occupational Illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person. This right includes, but is not limited to, the Covered Person's rights under uninsured and underinsured motorist coverage, any No-Fault Auto Insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as the Covered Person's rights under the Plan to bring an action to clarify his or her rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on behalf of the Covered Person, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

The Covered Person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that the Covered Person fails to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Covered Person shall be borne solely by the Covered Person.

SELF-PAY CONTINUATION OF COVERAGE OPTIONS

The Consolidated Omnibus Budget Reconciliation Act of 1985 (SELF-PAY CONTINUATION OF COVERAGE) requires that most employers sponsoring a group health plan (Plan) offer employees and their eligible family members covered under their health plan the opportunity to elect a temporary extension of health coverage (called "SELF-PAY CONTINUATION OF COVERAGE") in certain instances where coverage under this Plan would otherwise end. This notice is intended to inform Plan Participants of rights and obligations under the continuation coverage provisions of SELF-PAY CONTINUATION OF COVERAGE, as amended and reflected in the final regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. To the extent this section conflicts with any SELF-PAY CONTINUATION OF COVERAGE law or regulation, SELF-PAY CONTINUATION OF COVERAGE law and regulations will govern.

Complete instructions on SELF-PAY CONTINUATION OF COVERAGE, as well as election forms and other information, will be provided by the Plan Administrator to the Plan Participants who become Qualified Beneficiaries under SELF-PAY CONTINUATION OF COVERAGE.

QUALIFIED BENEFICIARY

The following individuals are considered Qualified Beneficiaries for purposes of SELF-PAY CONTINUATION OF COVERAGE:

(1) A covered Employee;

(2) A covered spouse of a covered Employee; or

(3) A covered dependent of a covered Employee

that experiences a Qualifying Event that causes a loss of Plan coverage within the maximum coverage period.

QUALIFYING EVENT

The following are Qualifying Events if they result in a loss of coverage:

(1) Voluntary or involuntary termination of the covered Employee's employment other than by reason of gross misconduct;

(2) Reduction of hours of the covered Employee's employment;

(3) Divorce or legal separation of the covered Employee from the Employee's spouse;

(4) Death of the covered Employee;

(5) A dependent child ceases to be a dependent under the generally applicable requirements of this Plan; or

(6) A covered Employee becomes entitled to benefits under Medicare.

NOTICE REQUIREMENTS

If the Qualifying Event is the Employer's bankruptcy filing or the covered Employee's death, termination, reduction in hours of employment or Medicare entitlement, the Employer must notify the Plan Administrator of the Qualifying Event within 30 days from the Qualifying Event or loss of coverage.

In the case of a divorce, legal separation or cessation of dependency, covered Employees and Qualified Beneficiaries are responsible for notifying the Plan Administrator within 60 days after the Qualifying Event that had occurred.

Complete instructions on how to elect continuation will be provided by the Plan Administrator within 14 days of receiving notice of the Qualifying Event. Covered Qualified Beneficiaries then have 60 days in which to elect continuation. The 60-day period is measured from the later of the date coverage terminates or the date of the election notice.

If continuation is not elected in that 60-day period, then the right to elect continuation ceases.

BENEFITS THAT MAY BE CONTINUED UNDER SELF-PAY CONTINUATION OF COVERAGE

SELF-PAY CONTINUATION OF COVERAGE must be identical to coverage that is provided to other beneficiaries under this Plan. The Qualified Beneficiary may, but is not required to, continue these benefits under SELF-PAY CONTINUATION OF COVERAGE. Benefits, if any, to be continued will be indicated by the Qualified Beneficiary at the time of SELF-PAY CONTINUATION OF COVERAGE enrollment. A child born to or placed for adoption with the covered Employee during the period of SELF-PAY CONTINUATION OF COVERAGE must also be offered these benefits.

Life insurance, accidental death and dismemberment and weekly income or long-term disability benefits are not considered eligible for continuance under SELF-PAY CONTINUATION OF COVERAGE.

A change affecting benefits under this Plan for active Employees will also apply to SELF-PAY CONTINUATION OF COVERAGE Qualified Beneficiaries. Qualified Beneficiaries will be allowed to make the same choices given to active Employees under this Plan, such as during periods of open enrollment by this Plan, if offered.

MAXIMUM TIME PERIODS

Continuation will be available for a Qualified Beneficiary up to the maximum time period as shown below.

Qualifying Event	Maximum Continuation Period
Employment ends, retirement, leave of absence, layoff or reduction in hours (except gross misconduct dismissal)	18 months
Qualified Beneficiary determined to be Totally Disabled (as defined by Social Security Administration) at time of Qualifying Event or within first 60 days of SELF-PAY CONTINUATION OF COVERAGE (Refer to “Disability Extension” section below for special requirements)	29 months
Divorce or legal separation	36 months
Death of an Employee	36 months
Dependent child loses eligibility	36 months
Medicare Entitlement	Refer to Medicare Entitlement section below

Multiple Qualifying Events

When a termination of employment or reduction in hours of the covered Employee results in a loss of coverage and is followed within the original 18-month (or 29-month if there has been a disability extension) continuation period by a second Qualifying Event that has a 36-month maximum coverage period, the 18-month (or 29-month) period (for the spouse and dependent children Qualified Beneficiaries) is extended to 36 months from the start of the original 18-month SELF-PAY CONTINUATION OF COVERAGE period under certain situations and not from the date of the second Qualifying Event. Combined or second Qualifying Events will not continue a Qualified Beneficiary’s coverage for more than 36 months beyond the date of the original Qualifying Event.

Medicare Entitlement

The maximum coverage period due to the Employee's Medicare entitlement is as follows:

(1) If the covered Employee becomes entitled to Medicare after electing SELF-PAY CONTINUATION OF COVERAGE, the covered spouse and dependent child(ren), who are Qualified Beneficiaries, may continue coverage for up to 18 months from the original Qualifying Event (termination of employment or reduction in hours).

Under the terms of this Plan, Medicare entitlement will not create a second Qualifying Event.

(2) If the covered Employee becomes entitled to Medicare before the Qualifying Event (termination of employment or reduction in hours), the covered spouse and dependent child(ren) can extend SELF-PAY CONTINUATION OF COVERAGE up to the greater of the following:

(a) 36 months from the date of Medicare enrollment; or

(b) 18 months from the Qualifying Event (termination of employment or reduction in hours).

DISABILITY EXTENSION

A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month SELF-PAY CONTINUATION OF COVERAGE period if that Qualified Beneficiary is determined to be disabled under the Title II or XVI Social Security Administration Act, provided each of the following conditions are met:

(1) The Qualifying Event must be the covered Employee's termination of employment or reduction in hours.

(2) The Qualified Beneficiary must be deemed disabled by the Social Security Administration at the time of the Qualifying Event or at any time during the first 60 days of SELF-PAY CONTINUATION OF COVERAGE.

(3) The Qualified Beneficiary must notify the Plan Administrator of the disability determination prior to the end of the initial 18-month SELF-PAY CONTINUATION OF COVERAGE period and within 60 days of the date of the determination letter from the Social Security Administration.

If the individual entitled to the disability extension has non-disabled family members who are entitled to SELF-PAY CONTINUATION OF COVERAGE, those non-disabled family members are also entitled to the disability extension.

Individuals who qualify for a disability extension must notify the Plan Administrator within 30 days of any final determination that disability has ended.

Premiums may be higher after the initial 18-month period for persons exercising the disability extension provisions of SELF-PAY CONTINUATION OF COVERAGE.

WHEN SELF-PAY CONTINUATION OF COVERAGE ENDS

Continued coverage will cease on the earliest of:

(1) The last day of the applicable maximum continuation period.

(2) The first day of any period for which timely payment is not made to this Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

(4) The date, after the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion of limitation with respect to any Pre-Existing Condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either Part A or Part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

This Plan can terminate for just cause the coverage of a Qualified Beneficiary on the same basis that this Plan terminates for just cause of similarly situated non-SELF-PAY CONTINUATION OF COVERAGE beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under this Plan solely because of the individual's relationship to a Qualified Beneficiary ceases, this Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

HIPAA PRIVACY REGULATION REQUIREMENTS

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to allow the Disclosure of Protected Health Information (PHI) as defined under HIPAA, to the Plan Sponsor.

This Plan will generally Use the Covered Persons' Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose the Covered Persons' PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose the Covered Persons' PHI as required by law and as permitted by authorization. Refer to the Plan's privacy notice for more information about the permitted Uses and Disclosure of PHI, the individuals' right and this Plan's legal duties regarding PHI.

The **USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA** within this section of the document specifies the terms under which the Plan may share PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of the Covered Persons' PHI. The Plan Sponsor will ensure that adequate separation exists between this Plan and the Plan Sponsor and that proper safeguards are established. This includes specifically identifying the Employee (s) or classes of Employees who will have access to PHI.

This Plan agrees that it will only disclose the Covered Persons' PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms contained in the **USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA** portion of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA

This section establishes the terms under which the Plan may share the Covered Persons' PHI with the Plan Sponsor, and limits the Uses and Disclosure that the Plan Sponsor may make of the Covered Persons' PHI.

This Plan shall disclose the Covered Persons' PHI to the Plan Sponsor only to the extent necessary for the purposes of Plan Administrative Functions.

The Plan Sponsor shall Use and/or Disclose the Covered Persons' PHI only to the extent necessary to perform Plan Administrative Functions which include Payment for health care or Health Care Operations performed on behalf of this Plan.

This Plan requires the Plan Sponsor to certify that the Insurance Coordinator and Chief Financial Officer are the only Employees who will access and Use the Covered Persons' PHI. The Plan Sponsor must further certify that such Employees will only access and Use PHI for the purposes set forth to perform necessary Plan Administrative Functions.

The Plan Sponsor is subject to **ALL** of the following restrictions that apply to the Use and Disclosure of the Covered Persons' PHI. The Plan Sponsor:

(a) Will only Use and Disclose the Covered Persons' PHI for Plan Administrative Functions, as required by law, or as permitted under the HIPAA regulations;

(b) Will require each of its subcontractors or agents to whom the Plan Sponsor may provide the Covered Persons' PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to their PHI;

(c) Will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

(d) Will promptly report to this Plan any impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

(e) Will allow the Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

(f) Will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Persons' PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA regulations;

(g) Will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. The Covered Person has a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan related purposes such as Payment of benefits or Health Care Operations;

(h) Will make its internal practices, books and records relating to the Use and Disclosure of the Covered Persons' PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

(i) Must, if feasible, return to this Plan or destroy all of the Covered Persons' PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs their PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

(j) Will ensure that adequate separation exists between this Plan and the Plan Sponsor so that the Covered Persons' PHI will be Used only for the purpose of Plan Administrative Functions;

(k) Will Use reasonable efforts to request only the minimum necessary type and amount of the Covered Persons' PHI to carry out functions for which the information is requested.

This Plan requires the Plan Sponsor to certify who will access and Use the Covered Persons' PHI. The Plan Sponsor must further certify that such Employees will only access and Use PHI for the purposes set forth to perform necessary Plan Administrative Functions.

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive the Covered Persons' PHI. If any of these Employees or workforce members Use or Disclose the Covered Persons' PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

Plan Administrator. Catholic Diocese of Lexington Health Care Benefits Plan is the benefit plan of Catholic Diocese of Lexington Health. The Plan Administrator and the Plan Sponsor is Catholic Diocese of Lexington Health. The Plan is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Catholic Diocese of Lexington Health to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Catholic Diocese of Lexington Health shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of this Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to this Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

Duties of the Plan Administrator.

(1) To administer this Plan in accordance with its terms.

(2) To interpret this Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to this Plan.

(6) To appoint a claims administrator to process claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

Plan Administrator Compensation. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by this Plan.

Fiduciary. A fiduciary exercises discretionary authority or control over management of this Plan or the disposition of its assets, renders investment advice to this Plan or has discretionary authority or responsibility in the administration of this Plan.

Fiduciary Duties. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their dependent(s), and defraying reasonable expenses of administering this Plan. These are duties which must be carried out:

(1) With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation; and

(2) By diversifying the investments of this Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) In accordance with the Plan documents to the extent that they agree with ERISA.

The Named Fiduciary. A "named fiduciary" is the one named in this Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under this Plan. These other persons become fiduciaries themselves and are responsible for their acts under this Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Claims Administrator Is Not A Fiduciary. The Claims Administrator is **not** a fiduciary under this Plan merely by virtue of processing claims in accordance with this Plan's rules as established by the Plan Administrator; provided however, that the Claims Administrator will be considered a fiduciary under this Plan to the extent the Claims Administrator assumes responsibility for final determination of claim appeals.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The Plan Administrator assumes the sole responsibility for funding the employee benefits. The Plan is intended to comply and be governed by the “Employee Retirement Income Security Act of 1974” (ERISA) and not state law. Therefore, state law governing guarantee funds may not cover benefits payable under the Plan if the Plan Administrator is unable to pay benefits.

The cost of this Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The Plan Administrator will set the level of Employee contributions. These Employee contributions will be used in funding the cost of this Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from this Plan through the Claims Administrator.

EXCESS RISK INSURANCE

The Plan Administrator has purchased excess risk insurance coverage which is intended to reimburse the Plan Administrator for certain losses incurred and paid under the Plan by the Plan Administrator. The excess risk insurance coverage is **not** a part of this Plan.

THE TRUST AGREEMENT

If this Plan is established under a Trust agreement, that agreement is made a part of this Plan. A copy of the appropriate agreement is available for examination by Employees and their dependent(s) at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee or dependent:

(1) A copy of the Trust agreement.

(2) A complete list of employers and employee organizations sponsoring this Plan.

Service of legal process may be made upon a Plan trustee.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, this Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If this Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate this Plan in whole or in part. This includes amending the benefits under this Plan or the Trust agreement (if any).

In the event there is a material reduction in covered services or benefits, the Plan Administrator will furnish Plan Participants a summary of material reductions no later than 60 days after the adoption of the modification or change. This 60-day rule does not apply if this information would be furnished in connection with a system of communication maintained by the Plan Sponsor or Plan Administrator at regular intervals of not more than 90 days.

EMPLOYEE RIGHTS UNDER ERISA

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

Receive Information About this Plan and Benefits. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Plan Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. Health care coverage for yourself, spouse or dependents may be continued if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your SELF-PAY CONTINUATION OF COVERAGE rights.

Exclusionary periods of coverage for Pre-Existing Conditions under your group health plan may be reduced or eliminated, if you have Creditable Coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect SELF-PAY CONTINUATION OF COVERAGE, when your SELF-PAY CONTINUATION OF COVERAGE ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-Existing Condition limitation exclusion for up to 12 months (up to 18 months for Late Enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan Participants, ERISA imposes duties upon people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fee. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions. If you should have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administrator, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician, nursing care by registered nurses (R.N.s), and does not provide for overnight stays.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Birthing Center means any freestanding health facility, place, professional office, or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery Confinement.

Brand Name Product means a brand name or trademark name, typically the originator of the product and is defined by First Data Bank or any other industry source when assigned a brand status. Brand status may change depending on the cost of the product as issued by the manufacturer.

Business Associate are entities (i.e. Fiserv Health - Benesight) that perform or assist in the performance of any of the activities or functions of the Covered Entity involving the Use and Disclosure of Individually Identifiable Health Information, including claim processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, repricing, legal, actuarial, accounting, consulting, data aggregation management, administrative accreditation or financial services.

Calendar Year means January 1st through December 31st of the same year.

Chiropractic Care/Spinal Manipulation means skeletal adjustments, manipulation or other Treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such Treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Complications of Pregnancy are determined as follows: These conditions are included before the Pregnancy ends: acute nephritis, ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy-related conditions will be covered that are considered to be as medically severe as those listed above. 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.

Confinement and Confined means an uninterrupted stay following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Congenital Anomaly is a physical developmental defect that is present at birth and identified within the first twelve months of birth.

Contracted Amount means the discounted amount negotiated by the Pharmacy Benefits Administrator with the Plan that is providing the Prescription Drug benefit. This amount may include applicable sales tax and Pharmacy dispensing fees associated with the dispensing of any Prescription.

Cosmetic Dentistry means unnecessary dental procedures.

Cosmetic Procedures are procedures which improve physical appearance.

Covered Entity are entities directly impacted by the limitations placed on the access, Use and Disclosure of PHI. They include:

- Health care providers who actually perform the health care services (i.e. Physicians, Hospitals and clinics);
- Health Plans that provide reimbursement or Payment for such health care services; and
- Health care clearinghouses that transmit PHI in electronic format as part of the HIPAA electronic data interchange (EDI) requirements.

Covered Person is an Employee or dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including SELF-PAY CONTINUATION OF COVERAGE), HMO membership, an individual health insurance policy, Medicaid or Medicare.

Days of coverage that occur before a "significant break in coverage" are not required to be counted towards Creditable Coverage. A "significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have Creditable Coverage as described herein.

Days in a waiting period or affiliation period and, with respect to an individual who elects SELF-PAY CONTINUATION OF COVERAGE during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second SELF-PAY CONTINUATION OF COVERAGE election period are not taken into account in determining whether a "significant break in coverage" has occurred.

Custodial Care means services that:

(1) Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or

(2) Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or

(3) Do not require continued administration by trained medical personnel.

De-identified is information that does not identify an individual and under which no reasonable basis exists to believe that the information can be used to identify an individual.

Dental Hygienist is a person who is currently licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensing and practice of dental hygiene and who works under the supervision and direction of a Dentist.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Durable Medical Equipment means medical equipment that:

(1) Can withstand repeated use;

(2) Is not disposable;

(3) Is used to serve a medical purpose;

(4) Is generally not useful to a person in the absence of an Illness or Injury; and

(5) Is appropriate for use in the home.

Employee means a person who is a regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Catholic Diocese of Lexington Health.

Enrollment Date is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental, Investigational or Unproven Services means medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, Treatments, procedures, drug therapies or devices that, at the time, are determined to be:

(1) Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or

(2) Subject to review and approval by any institutional review board for the proposed use; or

(3) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

(4) A service that does not meet the definition of Medically Necessary.

Family Unit is the covered Employee and the family members who are covered as dependents under this Plan.

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic Product means a non-Brand Name Product which is a pharmaceutical equivalent to a Brand Name Product, but is typically sold at a lower cost and is defined by First Data Bank or any other industry source, when assigned a generic status. Generic status often changes depending on the cost of the product as issued by the manufacturer.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Health Care Operations include general administrative and business functions necessary for the Covered Entity to remain a viable business. These activities include:

- conducting quality assessment and improvement activities;
- reviewing the competence or qualifications and accrediting/licensing of health care professionals and plans;
- evaluating health care professional and health plan performance,
- training future health care professionals;
- insurance activities relating to the renewal of a contract for insurance;
- conducting or arranging for medical review and auditing services;
- compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- contacting of health care providers and patients with information about Treatment alternatives, and related functions that do not entail direct patient care; and
- activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the home health care is in place of Hospital Confinement; and it must specify the type and extent of home health care required for the Treatment of the patient.

Hospice Agency is an organization whose main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, and home care.

Hospice Unit is a facility or separate Hospital Unit that provides Treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and Treatment of sick or injured persons on an inpatient or outpatient basis at the patient's expense and which fully meets these tests:

- It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations;
- It is approved by Medicare as a Hospital;
- It maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and Treatment of sick and injured persons by or under the supervision of a staff of Physicians;
- It continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (RNs); and
- It is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the Treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time Confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (RN); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for Treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness, Mental Disorder, Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Inpatient Rehabilitation Facility is a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, Occupational Therapy and/or speech therapy) on an inpatient basis as authorized by law.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and Treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (RN) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under this Plan other than during the first 31-day period in which the individual is eligible to enroll under this Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan, whether in one period of time or in separate periods of time. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Maintenance Therapy means medical or non-medical health-related services that do not seek to cure, or that which are provided during periods when the medical condition of the patient is not changing, or does not require continued administration by medical personnel.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary or Medical Necessity means health care services and supplies which are determined by the Plan to be medically appropriate. In addition these health care services and supplies must be:

(1) Necessary to meet the basic health needs of the Covered Person;

(2) Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply;

(3) Consistent in type, frequency and duration of Treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by this Plan;

(4) Consistent with the diagnosis of the condition;

(5) Required for reasons other than the convenience of the Covered Person or his or her Physician; and

(6) Demonstrated through prevailing peer-reviewed medical literature to be either;

- **(a)** Safe and effective for treating or diagnosing the condition or Illness for which their use is proposed, or
- **(b)** Safe with promising efficacy
  - **(i)** for treating a life threatening Illness or condition,
  - **(ii)** in a clinically controlled research setting; and
  - **(iii)** using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For the purpose of this definition, the term “life threatening” is used to describe Illnesses or conditions, which are more likely than not to cause death within one year of the date of the request for Treatment.

The fact that a Physician has performed or prescribed a procedure or Treatment or the fact that it may be the only Treatment for a particular Injury, Illness or Mental Disorder does not mean that it is Medically Necessary, as defined. The definition of Medically Necessary used herein relates only to coverage and differs from the way in which a Physician engaged in the practice of medicine may define Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Medicine or Medication means a substance or preparation that alleviates or treats an Illness, disease, or Injury and may be available by Prescription only or over-the-counter (OTC). Medicine includes only substances and preparations that qualify as a medical expense under the Internal Revenue Code §213. Medicines or Medications (as defined by the plan) are not cosmetic in nature, nor merely beneficial to a person's general health.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables (or similar actuarial tables) for a person of the same height, age and mobility as the Covered Person.

Name Brand Drug means a drug that is marketed under a trademarked or patent protected name.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Participating Pharmacy means any Pharmacy that is not contracted by Pharmacy Benefits Administrator and is excluded from the network of pharmacies.

Non-Prescription Drug means an over-the-counter (OTC) Medication or supply normally purchased without a Prescription and which are prepackaged for use by the consumer and labeled in accordance with the requirements and statutes and regulations of any state and the federal government.

Non-URN Transplant Facility is a facility, to which this Plan has access, that has not entered into an agreement with United Resource Network (URN) to provide Approved Transplant Services.

Occupational Therapy is Treatment of a physically disabled Covered Person by means of constructive activities designed and adapted to promote the restoration of the person's ability to accomplish satisfactorily any ordinary tasks of daily living and those required by the person's particular occupation.

Outpatient Care is Treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in an Ambulatory Surgical Center.

Partial Hospitalization means Treatment received in a residential setting for Mental Disorder or Substance Abuse Treatment which is provided in a less restrictive manner than are inpatient services, but in a more intensive manner than are outpatient services. Acceptable residential settings include: half-way houses, three-quarter-way houses, and participation in an independent living center program.

Participating Pharmacy means any Pharmacy that is contracted by Pharmacy Benefits Administrator to be included in a network of pharmacies at a Contracted Amount.

Payment means the activities of the Health Plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Pharmacy Benefits Administrator is Innoviant, an organization that manages Prescriptionbenefits under this Plan.

Pharmacy and Therapeutics Committee is a committee comprised of independent physicians and pharmacists, organized by the Pharmacy Benefits Administrator that meets on a quarterly basis to review Medications and supplies.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatric Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Speech Language Pathologist, Psychiatrist, Psychologist (Ph.D.), Licensed Clinical Social Worker (L.C.S.W.), Licensed Social Worker (L.S.W.), Master of Social Work (M.S.W.), Social Worker (S.W.).

For purposes of this Plan, the definition of Physician does not include the following: Marriage, Family and Child Counselor (M.F.C.C.).

Plan means Catholic Diocese of Lexington Health Care Benefits Plan, which is a benefits plan for certain Employees of Catholic Diocese of Lexington and is described in this document.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Plan Participant is any Employee or dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of this Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six (6) months prior to the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to pregnancy, to a newborn child who is covered under this Plan within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The Pre-Existing Condition Limitation will apply to newborn, adopted, or child(ren) placed for adoption if there is a lapse of Creditable Coverage for a period of 63 days or more.

Preferred Products List means a list of products that have been determined by the Pharmacy and Therapeutics Committee to be clinically appropriate for reimbursement at the preferred level of benefits as indicated in the Prescription Drug Benefits Schedule. The Pharmacy and Therapeutics Committee will review and modify this list periodically, as new information becomes available. The Pharmacy Benefits Administrator will make available a copy of the Preferred Products List to the Plan, participating providers, Covered Persons and pharmacists.

Pregnancy is childbirth and conditions associated with Pregnancy, including Complications of Pregnancy.

Prescriber means any person licensed under the medical professional laws of the state where they are licensed to prescribe and administer Medications and supplies.

Prescription means any order authorized by a Prescriber for a Prescription or Non-Prescription product, that could be a Medication or supply for the person for whom prescribed. The Prescription must be compliant with all applicable laws and regulations and identify the name of the Prescriber and the name of the person for whom prescribed. It must also identify the name, strength, quantity and the directions for use of the Medication or supply prescribed.

Prescription Drug means a drug, which is approved by the FDA, is labeled "Rx only" and is prescribed by a Prescriber licensed under state law.

Prior Authorization List means a list of Prescription products that are Food and Drug Administration (FDA) approved for a specific diagnosis or as second line therapy, identified by the Pharmacy and Therapeutics Committee for which the Pharmacy Benefits Administrator requires medical information from the Prescriber to determine the appropriate level of coverage. The Pharmacy and Therapeutics Committee or Pharmacy Benefits Administrator will review and modify this list periodically, as new information becomes available.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information that is transmitted by electronic media; or maintained in any medium that is considered electronic media, or transmitted or maintained in any other form or medium.

Qualified Beneficiary is the following individuals (for purposes of SELF-PAY CONTINUATION OF COVERAGE):

(1) A covered Employee;

(2) A covered spouse of a covered Employee; or

(3) A covered dependent of a covered Employee

that experiences a Qualifying Event that causes a loss of Plan coverage within the maximum coverage period.

Qualifying Event is the following if they result in a loss of coverage:

(1) Voluntary or involuntary termination of the covered Employee's employment other than by reason of gross misconduct;

(2) Reduction of hours of the covered Employee's employment;

(3) Divorce or legal separation of the covered Employee from the Employee's spouse;

(4) Death of the covered Employee;

(5) A dependent child ceases to be a dependent under the generally applicable requirements of this Plan; or

(6) A covered Employee becomes entitled to benefits under Medicare.

Quantity Limits means limiting the dispensing quantities applied to Medications that are appropriate for acute use and are designed to provide sufficient amounts for the Treatment of one or more acute episodes, based on the Food and Drug Administration (FDA) guidelines, clinical recommendations published in peer review journals, as well as manufacturer packaging and labeling instructions. Some Quantity Limits are based on the number of units per dispensing while others are specified as a per month limit. The Pharmacy and Therapeutics Committee or the Pharmacy Benefits Administrator will review and modify this list periodically, as new information becomes available.

Reconstructive Surgery means surgery which is incidental to an Injury, Illness or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such surgery as cosmetic when a physical impairment exists, and the surgery restores or improves function. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify surgery done to relieve such consequences or behavior as Reconstructive Surgery.

Skilled Care Services & Supplies are skilled nursing and skilled rehabilitation services and supplies, which meet all of the following criteria:

(1) Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;

(2) Are ordered by a Physician; and

(3) Are necessary for the Treatment of the Illness, Injury or Pregnancy.

Determination of benefits for Skilled Care Services & Supplies is made based on both the skilled nature of the service or supply and the need for Physician-directed medical management. A service will not be determined to be “skilled” simply because there is not an available caregiver.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (RN) or by a licensed practical nurse (LPN) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home or any other similar facility.

Substance Abuse Treatment is for the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Summary Health Information is information that may be Individually Identifiable Health Information that summarizes claims history, claims experience or the type of claims experience of a Covered Person with the following identifiers removed:

- Names;
- Geographic units – information more specific than a state (five-digit zip codes are allowed);
- Dates – any month or day (except the year) directly relating to individuals or their Treatment including birth date, admission date, or date of death. Listing the individuals' age is allowed with the exception of individuals over the age of 89. For individuals over the age of 89, any month, day or year that reveals the individuals' age to be over 89, must be removed;
- Numbers – Social Security numbers, phone numbers, fax numbers, vehicle identifiers and all other identifying numbers as required by the regulations.

Temporomandibular Joint (TMJ) Syndrome is the Treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and Treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of an Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Illness.

In the case of a dependent, Total Disability (Totally Disabled) means the complete inability as a result of Injury or Illness to perform the normal activities of a person of like age and sex in good health.

Treatment(s) is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

URN Transplant Facility is a facility, to which this Plan has access, which has entered into an agreement with United Resources Network (URN) to render Approved Transplant Services. The Plan will provide a list of URN Transplant Facilities upon request.

Urgent Care Facility is a facility that provides services that are required to prevent serious deterioration of patients' health and that are required as a result of an unforeseen Illness, Injury or the onset of acute or severe symptoms.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is lesser than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.