Schreiner University Company Employee Benefit Plan

Master Plan Document & Summary Plan Description

70/30 Consumer Plan and High Deductible Health Plan

Plan Revision Date: 06/01/14
Plan Effective Date: 06/01/11
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INTRODUCTION

The purpose of this document is to provide you and your covered dependents, if any, with summary information on benefits available under this plan as well as information on a covered person’s rights and obligations under the Schreiner University Health Benefit Plan (the Plan). As a valued employee of Schreiner University, we are pleased to sponsor this Plan to provide benefits that can help meet your health care needs. Please read this document carefully and contact your Human Resource or Personnel office if you have questions.

Schreiner University is the named Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrator for this Plan is Healthgram, Inc. for medical claims, and Express Scripts for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

The Schreiner University Group Health Insurance Plan is a “church plan” within the meaning of the Internal Revenue Code and the Employee Retirement Income Security Act of 1974 (ERISA). It is not a group insurance contract within the meaning of state group insurance laws. Therefore, the Schreiner University Plan is not subject to the mandated benefit requirements imposed by state group insurance laws. To the extent that state laws other than those applicable to a group insurance contracts may legally require the Schreiner University Plan to provide a particular benefit, the Schreiner University Plan will conform to the state mandate, unless the mandated benefit would conflict with the doctrine or tenets of the Church.

Individuals covered under this Plan will be receiving an identification card to present to the provider whenever services are received. On this card are phone numbers to call in case of questions or problems.

This document summarized the benefits and limitations of the Plan and is known as a Summary Plan Description (SPD).

The document becomes effective on June 1, 2014.
PLAN INFORMATION

EMPLOYER ID NUMBER: 741193459

PLAN NUMBER: 501

PLAN EFFECTIVE DATE: 6/1/11

PLAN REVISION DATE: 6/1/14

EMPLOYEE GROUPS COVERED IN THIS SUMMARY:
This Summary Plan Description and Master Plan Document applies to all eligible employees of Schreiner University and its participating subsidiaries.

EMPLOYER/PLAN SPONSOR/PLAN ADMINISTRATOR:
Schreiner University
2100 Memorial Blvd.
Kerrville, TX 78028
830-896-5411

AGENT FOR SERVICE OF LEGAL PROCESS:
The Plan Administrator named above is the agent for service of legal process.

PLAN SUPERVISOR:
Healthgram, Inc., Inc.
P.O. Box 11088
Charlotte, NC 28220-1088
(704) 523-2758

PLAN YEAR/CALENDAR YEAR:
The financial records of the Plan are kept on a plan year basis. The plan year will begin each June 1 and end on May 31. Deductible and co-insurance information is maintained on a plan year basis.

TYPE OF ADMINISTRATION:
The Plan Administrator has complete power and discretionary authority to manage and administer the Plan. The Plan Administrator may delegate any assigned administrative duties to one or more designated persons or entities. Processing of initial claims has been delegated to the Plan Supervisor; however, the duties of the Plan Supervisor are merely ministerial in nature and no discretionary authority or responsibility for the Plan has been conferred on or delegated to the Plan Supervisor.

Plan Benefits
The Plan is an employee welfare benefits plan providing medical benefits. The Plan provides benefits only for those covered medical expenses specifically listed in this Summary Plan Description (See the Schedule of Benefits and Covered Medical Expenses sections.)

Funding
The Plan is funded by contributions from the Plan Sponsor and covered employees. The Plan Sponsor determines the level of contributions required, if any, from each participant and reserves the right to evaluate and modify the level of contributions from time to time. The application for enrollment and coverage authorizes the Plan Sponsor to make any required payroll deductions.
HIPAA Privacy Official
Questions about the Plan’s privacy policies and procedures and privacy complaints must be directed to:

    Alison Harpster
    Privacy Official
    200 S. Wacker Drive, Suite 1000
    Chicago, IL 60606
    888-260-7417

High Deductible Health Plan
This Plan is designed to meet the standards of a Qualifying High Deductible Health Plan under IRC Section 223.
SCHEDULE OF BENEFITS 70/30 CONSUMER PLAN

Medical Benefits
When injury or illness cause the member or the member’s dependents, while covered under this Plan, to incur Covered Medical Expenses, the Plan will determine benefits according to the provisions described in this Summary Plan Description and Master Plan Document. Benefits for each Covered Medical Expense will be calculated as follows:

1. The lesser of the actual, negotiated or Plan Allowance fee will be determined.
2. The allowable charge will be reduced by any applicable deductible and multiplied by the appropriate co-insurance rate, resulting in the benefit payable.
3. The benefit payable will be subject to all the terms, conditions and limitations of the Plan.

Payment
Covered expenses will only be paid if all of the following criteria are met:
1. The service is performed or provided on or after the member effective date.
2. The service is performed or provided prior to termination of coverage.
3. The service is provided by a provider within the scope of his or her license.
4. The Care Management Services requirements have been met.
5. The service is Medically Necessary.
6. The service is not subject to an Exclusion as provided in the Plan.

Care Management Requirements
Your Plan includes one or more features to help control the cost of medical care coverage. Some features will affect the amount of benefits payable for covered expenses. (See the Care Management Requirements section for details).

Please note that the Plan is not directly involved in treatment, but only provides benefits for services that are covered under the terms of the Plan. Therefore, the Plan has no liability for the quality of care you may receive. The member and health care provider(s) are responsible for making all decisions regarding your health care and will control the course of treatment followed.

Pre-certification
Hospital admissions, outpatient surgeries and other procedures require pre-certification. If pre-certification is not obtained, a penalty will apply and benefits will be reduced and/or denied. (See the Care Management Services section for details).

In – Network Services
The Plan uses In-Network Providers. “In-Network Providers” are contracted either directly by the Plan or through other provider networks that are supplementary to the Plan. An “Out-of-Network provider” is one who has not elected to participate as an in-network provider in the Plan. Schreiner University will use the Private Health Care Systems (PHCS) network. You can access the Provider Directories on-line at the following web addresses to check for participating physicians:

www.phcs.com

Two different levels of benefits are provided under the Plan:

1. The “In-Network” benefit level will be payable for services rendered by a participating provider.
2. The “Out-of- Network” benefit level will be payable for services rendered by a provider who is not a participating provider.
Out-of-Area Benefits
Charges for Covered Medical Expenses rendered by a provider where a network arrangement does not exist will be considered as out-of-area charges.

Emergency Services
Charges for Emergency Services do not require pre-certification and are covered as in-network (See Definitions).

Plan Year Deductible
A covered person’s deductible requirement will be met when Covered Medical Expenses and Prescription Expenses paid by that person during each calendar year equal the deductible amount. The covered person is responsible for paying the calendar year deductible. The Plan will not reimburse the covered person for this expense.

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Family</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

Co-Insurance Rate
Co-Insurance rate is the percentage of Covered Medical Expenses and Prescription Expenses payable by the Plan after the deductible requirement is met. The co-insurance rate for each type of service is listed in the Schedule of Benefits.

Standard Organ Transplant Benefit
If a covered person does not meet all the requirements outlined in the Organ Transplant Program under Care Management Requirement, the co-insurance rate is 50% with a maximum benefit of $100,000.

Out-of-Pocket Limit
If the total amount of out-of-pocket expenses for deductibles, copayments, and co-insurance meets the limit set forth below, then the Plan will pay 100% for any additional covered expenses incurred during the remainder of the calendar year.

If a covered person has health coverage from any other source where coordination of benefits is allowable, the amounts paid do not accrue toward the out-of-pocket limit.

Non-covered charges, negotiated reduction in charges, benefit reduction for failure to comply with pre-certification and Care Management Service Requirements, and charges in excess of Plan Allowance do not accrue toward the out-of-pocket limit for the year.

<table>
<thead>
<tr>
<th>Out-of-Pocket Limit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Family</td>
<td>$12,500</td>
<td>$25,000</td>
</tr>
</tbody>
</table>
### PRIMARY CARE SERVICES

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network</th>
<th>Out-of-Network (Subject to the Plan Allowance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Charges of primary care physician for a visit to the office</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>2. Office surgery charges</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
</tbody>
</table>

### WELLNESS and PREVENTIVE SERVICES

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network</th>
<th>Out-of-Network (Subject to the Plan Allowance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Routine Physical exams</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>2. Routine child care</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>3. Gynecological exams</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>4. Mammogram</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>5. Routine Colonoscopies</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>6. Routine Sigmoidoscopies</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>7. Prostate, PSA and rectal exams for men</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>8. Immunizations</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>9. Hearing Exams</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>10. X-rays and lab services provided during the exam</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>11. Contraceptives</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>12. Preventive Services*</td>
<td>Payable at 100%</td>
<td>Payable at 50% after deductible</td>
</tr>
</tbody>
</table>

### Covered Preventive Services for Adults

- Abdominal Aortic Aneurysm
- Alcohol Misuse
- Blood Pressure
- Cholesterol
- Colorectal Cancer
- Depression
- Type 2 Diabetes

### Covered Preventive Services for Women, Including Pregnant Women

- Anemia
- Bacteriuria
- Breast Cancer Mammography
- Cervical Cancer
- Chlamydia Infection
- Domestic and

### Covered Preventive Services for Children

- Alcohol and Drug Use
- Autism
- Behavioral Assessments
- Blood Pressure
- Cervical Dysplasia
- Congenital
- Hypothyroidism
• HIV
• Obesity
• Tobacco Use
• Syphilis
• Counseling (PCP Office Visit)
• Diet
• Sexually Transmitted Infection
• Aspirin
• Immunizations

Interpersonal Violence
• Gestational Diabetes
• Gonorrhea
• Hepatitis B
• HIV
• Osteoporosis
• Rh Incompatibility
• Tobacco Use
• Counseling (PCP Office Visit)
• BRCA
• Breast Cancer
• Chemoprevention
• Breastfeeding
• Sexually Transmitted Infection
• Breastfeeding Rental Equipment
• Contraceptives
• Folic Acids
• Human Papillomavirus
• DNA Test
• Well-Woman Visits

• Depression
• Developmental
• Dyslipidemia
• Hearing
• Hematocrit or Hemoglobin
• Hemoglobinopathies
• HIV
• Lead
• Obesity
• Oral Health
• Phenylketonuria (PKU)
• Sexually Transmitted Infection (STI)
• Vision
• Fluoride
• Chemoprevention
• Gonorrhea Preventive Medication
• Height, Weight, and BMI
• Immunizations
• Iron Supplements
• Tuberculin Testing

* For a complete list of covered preventive services go to [www.healthcare.gov](http://www.healthcare.gov).

**OTHER COVERED SERVICES**

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network</th>
<th>Out-of-Network (Subject to the Plan Allowance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Charges of a specialist for a visit to the office including surgical procedures</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>2. All other services rendered by a physician</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>3. Charges for outpatient independent lab referred by physicians for illnesses not otherwise outlined in the Schedule of Benefits</td>
<td>Payable at 100% deductible waived</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>4. Quest Diagnostic Lab</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 100%, deductible waived</td>
</tr>
<tr>
<td>5. Charges of a hospital (facility) for outpatient treatment</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>6. Charges of a hospital (facility) for inpatient treatment</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>Services</td>
<td>In-Network</td>
<td>Out-of-Network (Subject to the Plan Allowance)</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>7. Charges of a hospital for emergency room care</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 70% after in-network deductible**</td>
</tr>
<tr>
<td>8. Charges of an emergency room physician***</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 70% after in-network deductible**</td>
</tr>
<tr>
<td>9. Charges of an ambulatory surgery center</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>10. Charges of an urgent care center</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>11. Charges for maternity services</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>12. Charges incurred which are considered out-of-area</td>
<td>Payable as In-Network</td>
<td></td>
</tr>
<tr>
<td>13. All other charges to include anesthesiologist, pathologist, radiologist***</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 70% after in-network deductible**</td>
</tr>
<tr>
<td>14. Durable Medical Equipment</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 70% after in-network deductible**</td>
</tr>
<tr>
<td>15. Home Health Care</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>16. Ambulance Service</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 70% after in-network deductible**</td>
</tr>
<tr>
<td>17. Extended Care Facility, Skilled Nursing Facility, or Rehabilitation Facility</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>18. Hospice Care</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>19. Physical, Speech, and Occupational Therapy</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>20. Cardiac Rehabilitation (Outpatient)</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
</tbody>
</table>

**In-network out-of-pocket limit also applies.  
***May be out-of-network even though hospital is in-network

**Pre-Certification Penalty**

Hospital admissions, outpatient surgeries and other procedures require pre-certification. Pre-certification is the responsibility of the member. If pre-certification is not obtained, benefits will be reduced by 50%. Co-insurance payments for services where pre-certification is not obtained do not accrue toward the co-insurance limits. (See the Care Management Requirements for a list of services requiring pre-certification).
<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network</th>
<th>Out-of-Network (Subject to the Plan Allowance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vertebral Manipulation/Outpatient Skeletal Adjustment/Acupuncture /Acupressure</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>(Plan year maximum 30 visits)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain Therapy / Pain Management</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>Sleep Studies</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction (TMJ)</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>Surgical Removal of Impacted Teeth</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 70% after in-network deductible**</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>Injections other than Allergy</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td>Medical Necessity Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artificial Limbs</td>
<td>Payable at 70% after deductible</td>
<td>Payable at 50% after deductible</td>
</tr>
<tr>
<td><em>Per limb limit $15,000</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**In-network out-of-pocket limit also applies.

This Schedule of Benefits may be revised as more information is made available regarding Healthcare Reform.

**Medical Emergency**
If you or one of your Dependents requires treatment for a Medical Emergency and cannot reasonably reach a PPO Provider, benefits for such treatment received will be paid at the same level as a PPO Provider.

**Uncontrollable Providers**
When services are provided at a PPO Hospital (inpatient, outpatient, and Hospital emergency room) or a licensed PPO freestanding surgical center, services provided by a Non-PPO emergency room Physician, anesthesiologist, radiologist, and pathologist will be payable at the PPO level. When services are provided at a Non-PPO Hospital (inpatient, outpatient, and Hospital emergency room) or a licensed Non-PPO provider charges are subject to the Non-PPO Prevailing Charges limitation.

**Outpatient Laboratory Services – Quest Diagnostics Lab Card Program**
Quest Diagnostics is a laboratory provider that conducts outpatient testing. An agreement has been established with Quest Diagnostics to provide these services at a negotiated rate.

“Laboratory Services” means Covered Charges for testing of materials, fluids, or tissues obtained from patients for the purpose of screening or diagnosing a condition and for determining appropriate treatment.
When you or your Dependent require outpatient Laboratory Services, you or your Physician may choose any laboratory you wish. However, if you use Quest Diagnostics, the benefits will be more favorable.

When utilizing Quest Diagnostics, there are two ways in which laboratory work is completed:
- Specimens are drawn at the Physician’s office and are sent to Quest Diagnostics for testing; or
- The covered individual visits a contracted Quest Diagnostics collection site with a Physician’s directive and has the specimen drawn. The specimen is then sent to Quest Diagnostics for testing.

If you or your Dependent goes to a Physician’s office or clinic and the Physician sends the laboratory work to Quest Diagnostics for processing, benefits will be paid as previously described in this section for the Laboratory Services.

If you or your Dependent goes to a Physician’s office or clinic and the Physician sends the laboratory work to a facility other than Quest Diagnostics, regular benefits will apply, including any applicable Deductibles.

If you or your Dependent goes to a Quest Diagnostics contracted collection site with a Physician’s directive, benefits will be paid as previously described in this section for the Laboratory Services.

If the laboratory facility is not Quest Diagnostics, regular benefits will apply including any applicable Deductibles. In connection with laboratory testing when a professional component is billed by a laboratory facility that is not Quest Diagnostics, said professional component will be considered a Covered Charge, including any applicable plan Deductible and coinsurance.

If you have questions about the Quest Diagnostics Lab Card program or need to find a participating lab, please call Quest Diagnostics’ Client Services at:

1-800-750-1253
www.labcardsselect.com
**PRESCRIPTION DRUG BENEFITS-70/30 CONSUMER PLAN**

The Plan includes a prescription drug benefit program, which uses an ID card and a network of participating pharmacies provided by Express Scripts, Inc. Participating pharmacies will accept the required copayment and file the claim directly. **Claims for expenses incurred at non-participating pharmacies and claims for prescriptions purchased without a drug card will not be covered by the Plan for members who have a valid drug card.**

The Plan includes a mail order prescription drug benefit program administered by Express Scripts, Inc. Refer to the member packet for complete instructions on how to use this program or call Express Scripts Customer service at 1-800-889-0350.

Express Scripts also offers online tools to manage prescription needs. To get detailed information via the web and learn about the Express Scripts programs and services, visit [www.express-scripts.com](http://www.express-scripts.com).

The prescription copayment rate varies depending on whether the prescription drug is classified as generic, formulary brand or non-formulary brand, as follows:

<table>
<thead>
<tr>
<th>Prescription Drug Card</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>Payable at 70% after deductible; maximum 90 day supply</td>
</tr>
<tr>
<td>Formulary Brand</td>
<td>Payable at 70% after deductible; maximum 90 day supply</td>
</tr>
<tr>
<td>Non-Formulary Brand</td>
<td>Payable at 70% after deductible; maximum 90 day supply</td>
</tr>
<tr>
<td>Oral and Injectable Contraceptives</td>
<td>Payable at 100%; deductible waived; maximum 90 day supply</td>
</tr>
<tr>
<td>Generic Contraceptives</td>
<td>Member pays 0% copay; maximum 90 day supply</td>
</tr>
</tbody>
</table>

**Note:** Diabetic Supplies are payable at 100% if prescription is obtained through Edgepark Medical Supplies. For more information please call 1-800-321-0591.

<table>
<thead>
<tr>
<th>Prescription Drug Mail Service*</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>Payable at 70% after deductible; maximum 90 day supply</td>
</tr>
<tr>
<td>Formulary Brand</td>
<td>Payable at 70% after deductible; maximum 90 day supply</td>
</tr>
<tr>
<td>Non-Formulary Brand</td>
<td>Payable at 70% after deductible; maximum 90 day supply</td>
</tr>
</tbody>
</table>

*A 90-day supply is available at the pharmacy.

**Covered Benefits:**
- Federal legend drugs
- Syringes and needles used only to inject insulin
- Insulin
- Oral and Injectable contraceptives
- Injectable, subject to pre-certification
- Smoking cessation products

**Payable at 100%**
- Generic contraceptives (USPSTF)
- Contraceptive injectables, subject to precertification
- Aspirin to prevent cardiovascular disease (CVD) (Men age 45 to 79 and Women age 55 to 79 years

**Exclusions:**
- Appetite Suppressants
- Experimental or Investigational drugs, including compounded medications for non-FDA approved use
- Fertility medications
- Ostomy supplies (covered through the medical plan)
- Retin-A, which may be covered with a letter of medical necessity
- Over-the-counter medications and equivalents
- Vitamins, except prenatal
- Rogaine
- Therapeutic devices or appliances, support garments, and other non-medical substances
• Oral fluoride supplementation (Children from birth through 5 years old)
• Iron supplementation (Children from birth to 12 months of age)
• Folic acid supplementation in women from age 18 to 45 years old
• Immunizations (USPSTF)

Injectable Drug Program for Chronic Diseases
CuraScript delivers high cost injectable drugs as well as certain oral medications used in the treatment of certain chronic diseases. The initial prescription requires precertification and must be filled at a pharmacy. All refills for these medications must be made through the program. After the first fill, members will receive a letter with instructions about getting their next refill through CuraScript. For more information call CuraScript Customer Service at 1-800-278-0980.
SCHEDULE OF BENEFITS HDHP 2500

Medical Benefits
When injury or illness cause the member or the member’s dependents, while covered under this Plan, to incur Covered Medical Expenses, the Plan will determine benefits according to the provisions described in this Summary Plan Description and Master Plan Document. Benefits for each Covered Medical Expense will be calculated as follows:

1. The lesser of the actual, negotiated or Plan Allowance fee will be determined.
2. The allowable charge will be reduced by any applicable deductible and multiplied by the appropriate co-insurance rate, resulting in the benefit payable.
3. The benefit payable will be subject to all the terms, conditions and limitations of the Plan.

Payment
Covered expenses will only be paid if all of the following criteria are met:
1. The service is performed or provided on or after the member effective date.
2. The service is performed or provided prior to termination of coverage.
3. The service is provided by a provider within the scope of his or her license.
4. The Care Management Services requirements have been met.
5. The service is Medically Necessary.
6. The service is not subject to an Exclusion as provided in the Plan.

Care Management Requirements
Your Plan includes one or more features to help control the cost of medical care coverage. Some features will affect the amount of benefits payable for covered expenses. (See the Care Management Requirements section for details).

Please note that the Plan is not directly involved in treatment, but only provides benefits for services that are covered under the terms of the Plan. Therefore, the Plan has no liability for the quality of care you may receive. The member and health care provider(s) are responsible for making all decisions regarding your health care and will control the course of treatment followed.

Pre-certification
Hospital admissions, outpatient surgeries and other procedures require pre-certification. If pre-certification is not obtained, a penalty will apply and benefits will be reduced and/or denied. (See the Care Management Services section for details).

In – Network Services
The Plan uses In-Network Providers. “In-Network Providers” are contracted either directly by the Plan or through other provider networks that are supplementary to the Plan. An “Out-of-Network provider” is one who has not elected to participate as an in-network provider in the Plan. Schreiner University will use the Private Health Care Systems (PHCS) network. You can access the Provider Directories on-line at the following web addresses to check for participating physicians:
www.phcs.com

Two different levels of benefits are provided under the Plan:

1. The “In-Network” benefit level will be payable for services rendered by a participating provider.
2. The “Out-of- Network” benefit level will be payable for services rendered by a provider who is not a participating provider.
Out-of-Area Benefits
Charges for Covered Medical Expenses rendered by a provider where a network arrangement does not exist will be considered as out-of-area charges.

Emergency Services
Charges for Emergency Services do not require pre-certification and are covered as in-network (See Definitions).

Plan Year Deductible
A covered person’s deductible requirement will be met when Covered Medical Expenses and Prescription Expenses paid by that person during each calendar year equal the deductible amount. The covered person is responsible for paying the calendar year deductible. The Plan will not reimburse the covered person for this expense. When the family plan is selected, no benefits will be payable for a family member until the entire family deductible amount has been met.

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,500</td>
<td>$5,000</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

Co-Insurance Rate
Co-Insurance rate is the percentage of Covered Medical Expenses and Prescription Expenses payable by the Plan after the deductible requirement is met. The co-insurance rate for each type of service is listed in the Schedule of Benefits.

Standard Organ Transplant Benefit
If a covered person does not meet all the requirements outlined in the Organ Transplant Program under Care Management Requirement, the co-insurance rate is 50% with a maximum benefit of $100,000.

Out-of-Pocket Limit
Once the covered person has satisfied the required calendar year deductible, the Plan will share the payment of covered charges according to the co-insurance rates listed in the Schedule of Benefits.

The Plan pays according to the co-insurance rate until the covered person has paid an amount equal to the out-of-pocket limit. Once the out-of-pocket limit has been met, the co-insurance rate will automatically increase to 100% for any additional covered expenses incurred by that same person during the remainder of the calendar year.

If a covered person has health coverage from any other source where coordination of benefits is allowable, the amounts paid do not accrue toward the out-of-pocket limit.

Copays, non-covered charges, negotiated reduction in charges, benefit reduction for failure to comply with pre-certification and Care Management Service Requirements, and charges in excess of Plan Allowance do not accrue toward the out-of-pocket limit for the year.

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Family</td>
<td>$10,000</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

Deductibles are included in the out-of-pocket limit.
### PRIMARY CARE SERVICES

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network</th>
<th>Out-of-Network (Subject to the Plan Allowance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Charges of primary care physician for a visit to the office</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>2. Office surgery charges</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
</tbody>
</table>

### WELLNESS AND PREVENTIVE SERVICES

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network</th>
<th>Out-of-Network (Subject to the Plan Allowance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Routine Physical exams</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>2. Routine child care</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>3. Gynecological exams</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>4. Mammogram</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>5. Routine Colonoscopies</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>6. Routine Sigmoidoscopies</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>7. Prostate, PSA and rectal exams for men</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>8. Immunizations</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>9. Hearing Exams</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>10. X-rays and lab services provided during the exam</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>11. Contraceptives</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>12. Preventive Services*</td>
<td>Payable at 100%</td>
<td>Payable at 60% after deductible</td>
</tr>
</tbody>
</table>

### Covered Preventive Services

#### Covered Preventive Services for Adults

- Abdominal Aortic Aneurysm
- Alcohol Misuse
- Blood Pressure
- Cholesterol
- Colorectal Cancer
- Depression
- Type 2 Diabetes

#### Covered Preventive Services for Women, Including Pregnant Women

- Anemia
- Bacteriuria
- Breast Cancer Mammarygraphy
- Cervical Cancer
- Chlamydia Infection
- Domestic and

#### Covered Preventive Services for Children

- Alcohol and Drug Use
- Autism
- Behavioral Assessments
- Blood Pressure
- Cervical Dysplasia
- Congenital
- Hypothyroidism
• HIV
• Obesity
• Tobacco Use
• Syphilis
• Counseling (PCP Office Visit)
• Diet
• Sexually Transmitted Infection
• Aspirin
• Immunizations

Interpersonal Violence
• Gestational Diabetes
• Gonorrhea
• Hepatitis B
• HIV
• Osteoporosis
• Rh Incompatibility
• Tobacco Use
• Counseling (PCP Office Visit)
• BRCA
• Breast Cancer Chemoprevention
• Breastfeeding
• Sexually Transmitted Infection
• Breastfeeding Rental Equipment
• Contraceptives
• Folic Acids
• Human Papillomavirus
• DNA Test
• Well-Woman Visits

• Depression
• Developmental
• Dyslipidemia
• Hearing
• Hematocrit or Hemoglobin
• Hemoglobinopathies
• HIV
• Lead
• Obesity
• Oral Health
• Phenylketonuria (PKU)
• Sexually Transmitted Infection (STI)
• Vision
• Fluoride Chemoprevention
• Gonorrhea Preventive Medication
• Height, Weight, and BMI
• Immunizations
• Iron Supplements
• Tuberculin Testing

* For a complete list of covered preventive services go to www.healthcare.gov.

**OTHER COVERED SERVICES**

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network</th>
<th>Out-of-Network (Subject to the Plan Allowance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Charges of a specialist for a visit to the office including surgical procedures</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>2. All other services rendered by a physician</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>3. Charges for outpatient independent lab referred by physicians for illnesses not otherwise outlined in the Schedule of Benefits</td>
<td>Payable at 100% deductible waived</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>4. Quest Diagnostic Lab</td>
<td>Payable at 100%, deductible waived</td>
<td>Payable at 100%, deductible waived</td>
</tr>
<tr>
<td>5. Charges of a hospital (facility) for outpatient treatment</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>6. Charges of a hospital (facility) for inpatient treatment</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>Services</td>
<td>In-Network</td>
<td>Out-of-Network (Subject to the Plan Allowance)</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>7. Charges of a hospital for emergency room care</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 90% after in-network deductible**</td>
</tr>
<tr>
<td>8. Charges of an emergency room physician***</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 90% after in-network deductible**</td>
</tr>
<tr>
<td>9. Charges of an ambulatory surgery center</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>10. Charges of an urgent care center</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>11. Charges for maternity services</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>12. Charges incurred which are considered out-of-area</td>
<td>Payable as In-Network</td>
<td></td>
</tr>
<tr>
<td>13. All other charges to include anesthesiologist, pathologist, radiologist***</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 90% after in-network deductible**</td>
</tr>
<tr>
<td>14. Durable Medical Equipment</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 90% after in-network deductible**</td>
</tr>
<tr>
<td>15. Home Health Care</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>16. Ambulance Service</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 90% after in-network deductible**</td>
</tr>
<tr>
<td>17. Extended Care Facility, Skilled Nursing Facility, or Rehabilitation Facility</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>18. Hospice Care</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>19. Physical, Speech, and Occupational Therapy</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>20. Cardiac Rehabilitation (Outpatient)</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
</tbody>
</table>

**In-network out-of-pocket also applies.***May be out-of-network even though hospital is in-network

**Pre-Certification Penalty**
Hospital admissions, outpatient surgeries and other procedures require pre-certification. Pre-certification is the responsibility of the member. If pre-certification is not obtained, benefits will be reduced by 50%. Co-insurance payments for services where pre-certification is not obtained do not accrue toward the co-insurance limits. (See the Care Management Requirements for a list of services requiring pre-certification).
SPECIAL SERVICES

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network</th>
<th>Out-of-Network (Subject to the Plan Allowance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vertebral Manipulation/Outpatient</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>Skeletal Adjustment/Acupuncture /Acupressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan year maximum 30 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain Therapy / Pain Management</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>Sleep Studies</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction (TMJ)</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>Surgical Removal of Impacted Teeth</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 90% after in-network deductible**</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>Injections other than Allergy</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>Medical Necessity Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artificial Limbs</td>
<td>Payable at 90% after deductible</td>
<td>Payable at 60% after deductible</td>
</tr>
<tr>
<td>Per limb limit $15,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**In-network out-of-pocket limit also applies.

This Schedule of Benefits may be revised as more information is made available regarding Healthcare Reform.

**Medical Emergency**
If you or one of your Dependents requires treatment for a Medical Emergency and cannot reasonably reach a PPO Provider, benefits for such treatment received will be paid at the same level as a PPO Provider.

**Uncontrollable Providers**
When services are provided at a PPO Hospital (inpatient, outpatient, and Hospital emergency room) or a licensed PPO freestanding surgical center, services provided by a Non-PPO emergency room Physician, anesthesiologist, radiologist, and pathologist will be payable at the PPO level. When services are provided at a Non-PPO Hospital (inpatient, outpatient, and Hospital emergency room) or a licensed Non-PPO provider charges are subject to the Non-PPO Prevailing Charges limitation.

**Outpatient Laboratory Services – Quest Diagnostics Lab Card Program**
Quest Diagnostics is a laboratory provider that conducts outpatient testing. An agreement has been established with Quest Diagnostics to provide these services at a negotiated rate.

“Laboratory Services” means Covered Charges for testing of materials, fluids, or tissues obtained from patients for the purpose of screening or diagnosing a condition and for determining appropriate treatment.

When you or your Dependent require outpatient Laboratory Services, you or your Physician may choose any laboratory you wish. However, if you use Quest Diagnostics, the benefits will be more favorable.
When utilizing Quest Diagnostics, there are two ways in which laboratory work is completed:

♦ Specimens are drawn at the Physician’s office and are sent to Quest Diagnostics for testing; or
♦ The covered individual visits a contracted Quest Diagnostics collection site with a Physician’s directive and has the specimen drawn. The specimen is then sent to Quest Diagnostics for testing.

If you or your Dependent goes to a Physician’s office or clinic and the Physician sends the laboratory work to Quest Diagnostics for processing, benefits will be paid as previously described in this section for the Laboratory Services.

If you or your Dependent goes to a Physician’s office or clinic and the Physician sends the laboratory work to a facility other than Quest Diagnostics, regular benefits will apply, including any applicable Deductibles.

If you or your Dependent goes to a Quest Diagnostics contracted collection site with a Physician’s directive, benefits will be paid as previously described in this section for the Laboratory Services.

If the laboratory facility is not Quest Diagnostics, regular benefits will apply including any applicable Deductibles. In connection with laboratory testing when a professional component is billed by a laboratory facility that is not Quest Diagnostics, said professional component will be considered a Covered Charge, including any applicable plan Deductible and coinsurance.

If you have questions about the Quest Diagnostics Lab Card program or need to find a participating lab, please call Quest Diagnostics’ Client Services at:

1-800-750-1253
www.labcardselect.com
The Plan includes a prescription drug benefit program, which uses an ID card and a network of participating pharmacies provided by Express Scripts, Inc. Participating pharmacies will accept the required copayment and file the claim directly. **Claims for expenses incurred at non-participating pharmacies and claims for prescriptions purchased without a drug card will not be covered by the Plan for members who have a valid drug card.**

The Plan includes a mail order prescription drug benefit program administered by Express Scripts, Inc. Refer to the member packet for complete instructions on how to use this program or call Express Scripts Customer service at 1-800-889-0350.

Express Scripts also offers online tools to manage prescription needs. To get detailed information via the web and learn about the Express Scripts programs and services, visit [www.express-scripts.com](http://www.express-scripts.com).

The prescription copayment rate varies depending on whether the prescription drug is classified as generic, formulary brand or non-formulary brand, as follows:

<table>
<thead>
<tr>
<th>Prescription Drug Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic: Payable at 90% after deductible; maximum 90 day supply</td>
</tr>
<tr>
<td>Formulary Brand: Payable at 90% after deductible; maximum 90 day supply</td>
</tr>
<tr>
<td>Non-Formulary Brand: Payable at 90% after deductible; maximum 90 day supply</td>
</tr>
<tr>
<td>Oral and Injectable Contraceptives: Payable at 100%; deductible waived; maximum 90 day supply</td>
</tr>
<tr>
<td>Generic Contraceptives: Member pays $0 copay; maximum 90 day supply</td>
</tr>
</tbody>
</table>

**Note:** Diabetic Supplies are payable at 100% if prescription is obtained through Edgepark Medical Supplies. For more information please call 1-800-321-0591.

<table>
<thead>
<tr>
<th>Prescription Drug Mail Service*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic: Payable at 90% after deductible; maximum 90 day supply</td>
</tr>
<tr>
<td>Formulary Brand: Payable at 90% after deductible; maximum 90 day supply</td>
</tr>
<tr>
<td>Non-Formulary Brand: Payable at 90% after deductible; maximum 90 day supply</td>
</tr>
</tbody>
</table>

*A 90-day supply is available at the pharmacy.*

**Covered Benefits:**
- Federal legend drugs
- Syringes and needles used only to inject insulin
- Insulin
- Oral and Injectable contraceptives
- Injectable, subject to precertification
- Smoking cessation products

**Payable at 100%**
- Generic contraceptives (USPSTF)
- Contraceptive injectables, subject to precertification
- Aspirin to prevent cardiovascular disease (CVD) (Men age 45 to 79 and Women age 55 to 79 years

**Exclusions:**
- Appetite Suppressants
- Experimental or Investigational drugs, including compounded medications for non-FDA approved use
- Fertility medications
- Ostomy supplies (covered through the medical plan)
- Retin-A, which may be covered with a letter of medical necessity
- Over-the-counter medications and equivalents
- Vitamins, except prenatal
- Rogaine
- Therapeutic devices or appliances, support garments, and other non-medical substances

22
- Oral fluoride supplementation (Children from birth through 5 years old)
- Iron supplementation (Children from birth to 12 months of age)
- Folic acid supplementation in women from age 18 to 45 years old
- Immunizations (USPSTF)

**Injectable Drug Program for Chronic Diseases**
CuraScript delivers high cost injectable drugs as well as certain oral medications used in the treatment of certain chronic diseases. The initial prescription requires precertification and must be filled at a pharmacy. All refills for these medications must be made through the program. After the first fill, members will receive a letter with instructions about getting their next refill through CuraScript. For more information call CuraScript Customer Service at 1-800-278-0980.
COVERED MEDICAL EXPENSES

The following expenses are covered by the Plan provided they are incurred for such care, services and supplies as prescribed by an attending physician while the person is covered under this Plan:

1. Charges for medically necessary abortions where the life of the mother is endangered if the pregnancy were to be carried to term or in the case of rape or incest.
2. Charges for acupuncture and acupressure.
3. Charges for medically necessary professional ambulance service to or from a hospital, or charges by regularly scheduled airline, railroad or air ambulance to the nearest hospital qualified to give the required treatment.
5. Charges by a physician or professional anesthetist for anesthesia and its administration.
6. When an assistant surgeon is required to render technical assistance during an operation, the covered expense for such services shall be limited to 20% of the approved charge for the primary surgeon.
7. Charges for blood or blood plasma and its administration, excluding any charges for blood or blood plasma which has been replaced by a donor.
8. Charges for the initial purchase of an external breast prosthesis or post mastectomy bra (up to two per year), prescribed in connection with a mastectomy for which the person is receiving benefits under the Plan (however, replacement of the initial breast prosthesis is not covered).
9. Charges for the circumcision of a newborn.
10. Charges for contraceptives, including, but not limited to implantable contraceptives (Norplant), injectable contraceptives (Depo-Provera), transdermal contraceptives, and diaphragms, which require disbursement by a physician or a physician's prescription. The associated office visit is also covered (See Definitions).
11. Charges for dental care or treatment performed by a dentist or physician for the following:
   b. Treatment of injury to sound natural teeth incurred as a result of a traumatic injury (other than an injury as a result of eating or chewing), including fixed bridgework and full or partial dentures and crowns, and rendered within twelve (12) months of the traumatic injury.
   c. Treatment for osteomyelitis as confirmed through pathology.
   d. Surgical removal of fully impacted wisdom teeth.
12. Charges for diabetic supplies to include insulin, syringes with or without needles, needles, alcohol swabs, blood glucose test strips, ketone test strips and tablets, lancets, and devices.
13. Charges for rental of durable medical equipment at home, including but not limited to mechanical equipment for the treatment of respiratory paralysis, wheelchairs, and hospital beds; however if the purchase price would be less than the rental cost for long-term usage, the Plan will pay for the purchase of such equipment upon approval from the Plan Supervisor, but not for any repair.
15. Charges by a home health care agency.
17. Hospital room and board charges, up to a daily maximum of the prevailing semi-private room rate.
18. Charges for the initial placement of artificial limbs or eyes.
19. Inpatient services and partial hospitalization services – Schreiner University will pay benefits for covered expenses incurred by the member or covered dependent for inpatient care and partial hospitalization care for mental health services and chemical dependency services provided in a hospital, health care treatment facility, psychiatric day treatment facility, crisis stabilization unit, or residential treatment center for children or adolescents.
20. Hospital charges for intensive care, cardiac care or other similar necessary accommodations.
21. Charges for **medically necessary** supplies such as **casts, splints or surgical dressings, trusses, braces (except dental) or crutches**.

22. Charges for medical care or treatment of **mental health disorders** (including ADD and ADHD).

23. **Miscellaneous hospital** charges (other than room and board) **required for** medical or surgical care or treatment.

24. Hospital charges for routine **newborn nursery care** and for the initial examination by a pediatrician at birth to determine the health of the infant.

25. Charges for medically necessary **nursing care** rendered by a registered nurse (R.N.) or, if none is available as certified by the attending physician, for services rendered by a Licensed Practical Nurse (L.P.N.), but only for nursing duties excluding custodial care and care by members of immediate family.


27. Charges for an **organ transplant incurred by** recipient and the organ donor if the recipient is covered under this Plan (See Organ Transplant Program for details).

28. Charges for **orthoptic** training (eye muscle exercises). Training by an optometrist does not have to be prescribed by a physician. Training by an orthoptic technician must be prescribed by a physician.

29. Charges for **oxygen** and rental of equipment for its administration.

30. Charges for **pain therapy** including, but not limited to, pain clinics and/or labs, epidural steroid injections for the treatment of pain, and all testing and therapies related to the treatment of pain or pain management.

31. Charges for **physical therapy and occupational therapy**, when services are provided by licensed therapists.


33. **Charges incurred by the covered female employee or spouse due to pregnancy, childbirth and related conditions** on the same basis as for illness (see Schedule of Benefits).

34. Charges for **prescription drugs** (including insulin) that are (i) ordered for the patient in writing by a physician and (ii) dispensed by a licensed pharmacist or a physician.

35. Charges for **rehabilitative care**, but only for necessary medical care (as prescribed by a physician) which is rendered in a rehabilitation facility or hospital, excluding custodial care or occupational training.

36. Charges for **routine physical examinations**.

37. Charges for treatment received in a **skilled nursing facility or extended care facility**.

38. Charges for sleep studies and treatment include diagnosis, testing, surgery and all charges associated with **sleeping disorders**.

39. Charges for **speech therapy** by a qualified speech therapist required because of an injury or illness other than psychosocial speech delay, behavior problems, attention disorder, conceptual disorder, or mental retardation. If therapy is required because of a congenital abnormality, the person must have had corrective surgery before therapy.

40. Charges for **sterilization** procedures, but not for the reversal of sterilization procedures.

41. Charges for medical care or treatment of **substance use disorders**.

42. Charges made by a physician for **surgical procedures** performed on an inpatient or outpatient basis. In the case of multiple surgical procedures performed through the same incision or separate incisions during the same operative session, the eligible expense for the surgeon will be the Plan Allowance charge or the contractual rate with the provider for the primary procedure, and 50% of the Plan Allowance charge or the contractual rate with the provider for the secondary procedure, and 50% of the Plan Allowance charge or the contractual rate with the provider for the third procedure.

43. Charges for outpatient **skeletal adjustment, adjunctive therapy, vertebral manipulation** and services for the care or treatment of dislocations or subluxations of the vertebrae.
44. Charges for **Temporomandibular Joint Dysfunction**, not to include: orthodontics, crowns, inlays or any appliance that is attached to or rests on the teeth.
45. Charges for **well baby care** services.
46. Charges for one **wig** per lifetime as a result of chemotherapy or radiation treatment.
47. Charges for diagnostic **x-ray or laboratory** examinations and their interpretation.
SPECIAL PROVISIONS

DENTAL SERVICES / ORTHODONTICS / ORAL SURGERY
Expenses for dental services and oral surgery are Covered Medical Expenses only if they are for the prompt repair of natural teeth, bone, or other body tissue needed as a result of a traumatic injury or malignancy. Treatment for cleft lip or cleft palate is covered as any other major medical expense.

DIALYSIS
Charges for professional fees and services, supplies, medications, labs, and facility fees related to outpatient dialysis are covered expenses. These services include but are not limited to Hemodialysis, Home Hemodialysis, Peritoneal dialysis and Hemofiltration. From the initial outpatient dialysis treatment, regardless of the member’s enrollment date with this plan, through the next 42 outpatient treatments, the Plan will pay in accordance with the major medical benefits contained in this Plan.

For subsequent treatment, the Plan Allowable for dialysis will be limited to 140% of current year Medicare. The Plan will pay 100% of the allowed amount for 30 consecutive months of dialysis or until the Plan is secondary to other coverage. Thereafter, standard coordination of benefits will apply.

Precertification and Utilization Review are required.

EXTENDED CARE, REHABILITATION AND SKILLED NURSING FACILITIES
Charges for services and supplies from qualified extended care, rehabilitation and skilled nursing facilities are Covered Medical Expenses. Services must be furnished to a covered person while confined to convalesce from an illness or injury and must occur during a convalescent period. The convalescent period is defined as the first day a covered person is admitted to a facility, if all of the following requirements are met:
1. The person was previously admitted to a hospital for at least three (3) days of inpatient treatment for an illness or injury.
2. The person is admitted to the extended care or rehabilitation facility within thirty (30) days after discharge from the hospital.
3. The person is admitted to the extended care or rehabilitation facility for services needed to convalesce from the condition that caused the hospital stay.

These covered services include skilled nursing and physical restorative care. Covered extended care or rehabilitation facility expenses do not include treatment for substance use disorder, chronic brain syndrome, alcoholism, senility, mental retardation or any other mental disorder.

Precertification and Utilization Review are required.

HOME HEALTH CARE
Covered Home Health Care Expenses include:
1. Part-time or intermittent care by an R.N., or by an L.P.N. if an R.N. is not available.
2. Part-time or intermittent home health services including private duty nursing provided by a licensed nurse.
3. Physical, occupation and speech therapy.
4. Medical supplies, medications or lab services ordered by a physician, which require nursing administration.

Precertification and Utilization Review are required.
HOSPICE CARE
Hospice care with an approved Hospice Care Program, whether inpatient or outpatient, is a covered benefit. An approved “Hospice Care Program” is a written plan of the care to be provided for the palliation and management of a person’s terminal illness developed by or under the supervision of the attending physician. “Palliative care” is a course of treatment that is primarily directed at lessening or controlling pain while maximizing comfort and does not attempt to cure the person’s terminal illness.

Pre-certification and Utilization Review are required.

HOSPITAL CARE
Intensive care in a hospital are Covered Medical Expenses. Private room charges are not Covered Medical Expenses be covered unless certified as medically necessary by the attending physician and pre-certified by Healthgram, Inc.

Pre-certification and Utilization Review are required.

MASTECTOMY-BREAST RECONSTRUCTION
Any covered person who is receiving benefits under the Plan in connection with a mastectomy and elects breast reconstruction shall be eligible for coverage of the following, to be provided in a manner determined in consultation with the attending physician and the patient:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgical reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications of mastectomy, including lymphedemas.

All of the benefits outlined above are subject to the Plan’s deductibles, copay, co-insurance, Plan Allowance charge limitations and Care Management Requirements. For more information, please contact the Plan Supervisor.

Pre-certification and Utilization Review are required.

MATERNITY HOSPITALIZATIONS
Under federal law, the Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a Cesarean section, or require that a provider obtain authorization from a plan for prescribing a length of stay not in excess of the above period. However, federal law does not prohibit the attending physician, after consultation with the mother, from discharging the mother or newborn before these periods have expired.

MENTAL HEALTH
Charges for treatment of mental health disorders (see Definitions) are Covered Medical Expenses. Charges for treatment of behavioral or learning disabilities are not covered. Prescription drugs used for these conditions are covered as any other prescription drugs, whether prescribed by a psychiatrist or medical doctor.

Pre-certification and Utilization Review are required for inpatient.

NEWBORN CARE
Routine newborn care includes hospital charges for room and board, services, supplies, and professional fees during the initial hospital confinement for in-hospital visits but only while the mother or infant is confined for delivery or post-delivery complications. Also included are charges for circumcision. (See Maternity Hospitalizations). (See Eligibility Requirements.)
ORGAN TRANSPLANTATION
See “Organ Transplant Program” in the CARE MANAGEMENT REQUIREMENTS section.

Pre-certification and Utilization Review are required.

PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY
Charges of a doctor or facility for physical, speech and occupational therapy that are covered expenses may be limited. The limitation applies for treatment received while the patient is not confined to the hospital as a bed patient (outpatient services). The limitation for treatment applies to the number of days that treatment may be received from the initial date of the accident, injury, or illness. A new period may begin 180 days after the last date of treatment for a given injury or illness. Speech therapy is not covered for psychosocial speech delay, behavior problems, attention disorder, conceptual disorder, or mental retardation.

PREVENTIVE SERVICES
Recommended Preventive Services are payable at 100% if services rendered are performed by an in-network provider. If a recommended preventive service is billed separately from an office visit or if the recommended preventive service is not the primary purpose of the office visit, copays, deductibles, and coinsurance still apply to the office visit.

For a complete list of covered preventive services go to www.healthcare.gov or visit your Human Resources department.

ROOM AND BOARD CHARGES
Charges by an institution for room and board and other necessary services and supplies must be regularly made at a daily or weekly rate. The semi-private rate is the charge that an institution applies to the beds in a semi-private room with two (2) or more beds. If a facility has private rooms only, it will be paid the same as the semi-private room charge.

SKELETAL ADJUSTMENT
Charges for the treatment of the skeletal system performed by external manipulation including, but not limited to, vertebral manipulation and associated adjunctive therapy are Covered Medical Expenses when medically necessary and when performed by physical therapists, chiropractors, osteopaths, and/or physicians.

SPEECH THERAPY
See Physical, Speech and Occupational Therapy.

SUBSTANCE USE DISORDERS
Charges for the treatment of substance use disorders are Covered Medical Expenses if all of the following requirements are met:
1. The treatment must be prescribed and supervised by a physician.
2. The treatment must have a follow-up therapy program directed by a physician on at least a monthly basis or include meetings at least twice a month with approved organizations devoted to the treatment of substance use disorders such as Alcoholics Anonymous or Narcotics Anonymous.

If a person is confined as an inpatient in a hospital, the covered charges include treatment of the medical complications of substance abuse/substance use. No room and board charges in excess of the semi-private room rate are covered.

If a person is confined as an inpatient in a non-hospital treatment facility, the covered charges include room and board charges equal to the semiprivate room rate. Charges are covered only for
facilities that are recognized by the Joint Commission on Accreditation of Hospitals and licensed by the state. No room and board charges in excess of the semi-private room rate are covered.

Pre-certification and Utilization Review are required for inpatient treatment.

VERTEBRAL MANIPULATION
See Skeletal Adjustment.
EXCLUSIONS

No benefits shall be payable under this Plan for any charges resulting from:

1. Charges for services performed more than twelve (12) months prior to receipt of the corresponding claim by the Plan Supervisor.
2. Charges for abortions, unless
   a. It is medically determined that the life or well being of the mother would be threatened by carrying the child to term.
   b. The pregnancy is the product of rape or incest.
   c. The fetus has a severe birth defect.
3. Illness or injury resulting from acts of war, insurrections, or atomic explosions.
4. Charges for treatment of any injury or illness resulting from: a commission of or an attempt to commit an assault or felony. Charges resulting from these activities are excluded whether the covered person was sane, insane, or under the influence of drugs at the time of the activity. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
5. Charges for treatment of an injury resulting from a motor vehicle accident in which a covered person has a blood alcohol concentration equal to or in excess of the level established by the laws of the state in which the accident occurred for driving while impaired or where the covered person has pled guilty or was convicted for violating those laws pertaining to driving while impaired or intoxicated for that state. Charges resulting from these activities are excluded whether the covered person was sane, insane, or under the influence of drugs at the time of the activity. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
6. Charges for attempted suicide or intentionally self-inflicted injury, while sane or insane, or an injury resulting from an act of aggression or battery initiated by the covered person. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
7. Expenses incurred before coverage begins or after coverage ends.
8. Charges for behavioral disorders or learning disabilities.
9. Charges for biofeedback or hypnosis.
10. Charges resulting from the following care, treatment or supplies for the feet, unless needed in treatment of diabetes and/or blood circulation problems:
   a. orthopedic shoes.
   b. orthopedic prescription devices to be attached to or placed in shoes.
   c. treatment of weak, strained, flat, unstable or unbalanced feet.
   d. treatment for metatarsalgia.
   e. treatment for bunions except for surgical treatments.
   f. treatment for infected, ingrown toenails, except for surgical procedures in office setting.
   g. treatment for corns, calluses or toenails.
11. Charges billed by a certified surgical assistant or technician (CSA, CST, LSA OR LST).
12. Charges in excess of Plan Allowance charges, where a contractual arrangement with the provider does not exist, including but not limited to physicians, hospitals, facilities, and providers of medical equipment and supplies.
13. Charges incurred as a result of complications arising from a service or procedure that is not a Covered Medical Expense.
14. Cosmetic, elective, plastic, reconstructive, or restorative surgery, except following illness or injury as specifically provided for in this Plan, including, but not limited to, rhinoplasty, abdominoplasty, lipectomy, liposuction, breast augmentation, face lifts, and complications arising from such services.
15. Treatment of injuries that result from participation in the following dangerous leisure activities:
   a. Pilot or co-pilot of an ultralight.
b. Racing including, but not limited to, competition in an automobile, motorcycle, balloon, hydroplane, powerboat, or ATV.
c. Participation in soaring, parachuting, skydiving, or bungee jumping.
d. Professional sports of any type.
This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
16. The difference between the charge for a service, procedure, or substance and the charge for a service, procedure, or substance that is known to be less expensive and would achieve the same or similar results with no additional medical risk.
17. All exercise programs or exercise equipment for treatment of any condition, outside of prescribed rehabilitation program.
18. Any Experimental or Investigational treatment, procedure, facility, equipment, service, device, substance, or drug, except for routine charges for services furnished in connection with participation in an Approved Clinical Trial. See the Definitions section.
19. Charges for genetic counseling and testing that are not needed for diagnosis or treatment of genetic abnormalities.
20. Any expenses for treatment, services, supplies, and facilities provided by or in a hospital owned or operated by any government or agency thereof where such care is provided at government expense under a plan or program established pursuant to the laws or regulations of any government or under a plan or program under which any government participates other than as an employer. The term “any government” includes the federal, veteran, state, provincial, municipal, or local government or, any political subdivision thereof, of the United States or of any other country. The Plan shall not exclude benefits for a covered person who received billable medical care at any of the above facilities.
21. Hearing aids, devices, and implants used to improve hearing.
22. Any expense or charge for the diagnosis or treatment of infertility in men or women including:
   a. Fertility studies or tests.
   b. Reversals of surgical sterilization including reconstruction of vasectomy or reconstruction of tubal ligation.
   c. Direct attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer.
   d. Supervision of pregnancy by infertility specialists who do not practice obstetrics.
23. Marital counseling, recreational, educational, or social therapy or training services or any form of non-medical self-care or self-help training and any related diagnostic testing, except for medically necessary patient education programs for diabetic and ostomy care.
24. Services and supplies that are not Medically Necessary except for covered wellness benefits.
25. Conditions arising out of or as a result of military service.
26. Medical services or supplies for which no charge was made or for which no payment would be required if the covered individual was not covered under this Plan.
27. Charges for services and supplies that are non-covered expenses.
28. Nutritional supplements, special foods, or vitamins not prescribed by a physician.
29. Any treatment of obesity or weight reduction, whether surgical or medical.
30. Professional services performed by the covered person or 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.
31. Any artificial, mechanical or cross-species organ or tissue transplant.
32. Charges for treatment outside of the United States. This exclusion does not apply to a resident of the United States traveling for business or pleasure that requires emergency medical treatment.
33. Personal comfort items such as television, telephones, extra food trays, etc.
34. Charges for pregnancy including delivery and complications for covered dependents other than the spouse of the covered employee.
35. **Replacement** braces for the leg, arm, back, neck; or **artificial arms** or **legs**, unless there is sufficient change in the covered person’s physical condition to make the original device no longer functional.

36. Services or supplies related to **sexual dysfunctions** or inadequacies including penile prosthesis, implants and all procedures and equipment developed for male impotency.

37. Charges for **shock wave therapy** for orthopedic procedures, including but not limited to the treatment of Plantar Fascitis, Patellar Tendonitis, Shoulder Tendonitis and Medial Epicondylitis.

38. Charges for **telephone** consultations, missed appointments, fees added for **filling out a claim form, and or fees**.

39. Charges related to hospital pre-certification, concurrent review, utilization **review, quality assurance, or case management**.

40. Expenses incurred after **termination of coverage** under this Plan.

41. Charges for routine examinations, periodic physical examinations, childhood checkups, examinations or services required or requested by any **third party**, including, but not limited to, such services for employment, license, insurance, school, or recreational purposes. This includes hospital charges to the extent they are allocable to scholastic **education, vocational training**, or for confinements resulting from a local or state mandate (court ordered).

42. Charges for which a **third party may be liable** (See “Third Party Recovery” section) or charges for which the covered person is **not legally required to pay**.

43. Care, services, or treatment for **transsexualism, gender dysphoria or sexual reassignment** or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

44. **Travel**, except for covered ambulance charges.

45. Charges incurred for any operation or **treatment for realignment of teeth or jaw or any other dental services not specifically provided for under Covered Medical Expenses**. Charges not covered include, but are not limited to: oral care or supplies for treatment of nerves connected to teeth, charges for treatment of atrophy of the lower jaw, occlusion, maxillofacial surgery, Temporomandibular Joint dysfunction, retrognathia, and related hospital and facility charges. The above charges are excluded unless otherwise provided in the Schedule of Benefits, or provided under DENTAL CARE/ORTHODONTICS/ORAL SURGERY (See the Special Provisions section). This exclusion shall not be construed to deny otherwise eligible expenses for the treatment of the teeth or jaws when such treatment is necessitated by traumatic injury that occurs within one year prior to the treatment.

46. **Vision care** including but not limited to eyeglasses, contact lenses, refractions, radial keratotomy, LASIK surgery and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error, unless covered by a vision benefit in the Plan.

47. Charges resulting from illness or injury covered by the **Worker’s Compensation Act** or similar law (See Workers Compensation Section).

48. Charges resulting from an accidental injury or illness arising out of, in connection with, or in the course of, **working for wages or profit** (past or present).
WORKERS’ COMPENSATION

This policy does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers’ Compensation Act or similar law is required or is otherwise available for the member.

If the Plan pays benefits for an injury or illness and the Plan determines the member also received Workers’ Compensation benefits by means of a settlement, judgment, or other payment for the same injury or illness, member shall reimburse the Plan in full all benefits paid by the Plan relating to the injury or illness.

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

ELIGIBILITY REQUIREMENTS

Requirements for Employee Coverage: A person will be automatically enrolled in the 70/30 Plan as of the first day of employment provided that all of the following requirements are met:
1. The person is a full-time employee of the Employer. An employee is full-time if regularly scheduled to work at least thirty (30) hours per week and on the regular payroll of the Employer.
2. The person is in a class eligible for coverage under the Plan. Members automatically enrolled may decline coverage or change plan options if written notice of such request is received by the Plan Administrator within the first thirty (30) days of enrollment.

Requirements for Dependent Coverage: A family member of an employee will become eligible for dependent coverage on the first day that the employee is eligible for employee coverage and the family member satisfies the requirements for dependent coverage.

Dependents eligible for coverage include:
1. The employee’s legally married spouse. *Spouse is defined as a person of the opposite sex, who is a husband or wife;*
2. The employee’s child (ren) until the end of the month in which he or she turns the age of twenty-six (26), including:
   a. A natural born child.
   b. A stepchild.
   c. An adopted child or a child lawfully placed with the employee for legal adoption by the employee. A “child lawfully placed with an employee for legal adoption” refers to a child whom the employee intends to adopt, whether or not the adoption has become final, provided that the child has not attained the age of eighteen (18) as of the date of placement for adoption. The child must be available for adoption, and the legal process must have commenced and be documented.
   d. An eligible foster child. An eligible foster child is an individual who is placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.
3. An employee’s unmarried child over the age of twenty-six (26) who is mentally or physically incapabe of earning his or her own living due to permanent, chronic, and total disability. The child may obtain continued coverage if, within thirty (30) days after the date coverage would otherwise terminate, the employee submits proof of the child’s incapacity (See Eligibility for Disabled Children); and
4. A child for whom the employee has legal guardianship and who is primarily dependent upon the employee for support and resides with the employee.

Note: The phrase “primarily dependent upon” shall mean dependent upon the covered employee for support and maintenance as defined by the Internal Revenue Code, and the covered employee must declare the dependent for purposes of taking an income tax exemption. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

At any time, the Plan Administrator may require documentation proving that a spouse or a child qualifies or continues to qualify as a dependent as defined by this Plan, including but not limited to marriage licenses, birth certificates, and/or a court order establishing a relationship of parent and child. If both husband and wife are employees, their children will be covered as dependents of the husband or wife, but not of both.
Any child of a Plan participant 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. A participant of the Plan may obtain from the Plan Administrator, without charge, a copy of the procedures governing QMCSO determinations.

**Eligibility for Disabled Children:** In order for a disabled child to be eligible for coverage under the Plan beyond the age of twenty-six (26), the child:

1. Must be enrolled in the Plan prior to the age of twenty-six (26).
2. Must be incapable of self-support because of mental retardation or permanent, chronic, and total disability which commenced prior to the age of twenty-six (26).
3. Must be primarily dependent upon the employee.
4. Must be continuously disabled and covered thereafter.
5. Must be considered disabled by the Social Security Administration.

If you believe a covered dependent meets the disability criteria above you may obtain a determination of disability from the Social Security Administration. This information must be submitted to the Plan Administrator within thirty (30) days prior to the covered dependent reaching the age of twenty-six (26). You may be required to submit additional information necessary for completion of the eligibility determination.

If such eligibility is approved, you may be further required (usually not more frequently than once a year) to furnish satisfactory evidence to substantiate the continued eligibility of the covered dependent under the Plan.

**Persons Excluded as Non-Dependents:** The term “dependent” excludes:

1. Any individuals living in the covered employee’s home who do not satisfy the eligibility requirements for dependents as defined by the Plan.
2. The legally separated or divorced former spouse of the employee.
3. Any person who is on active duty in any military service of any country.
4. Any person who is covered under the Plan as an employee.

If a person covered under this Plan changes his or her 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 and all amounts applied to benefit maximums.

**ENROLLMENT REQUIREMENTS**

**Enrollment**

An eligible employee must enroll for coverage by filling out and signing an enrollment application. The covered employee is also required to enroll for dependent coverage, if dependent coverage is desired.

Under the Plan, members are classified as “timely,” “late” or “special” enrollees depending on when the completed enrollment form is received by the Plan Administrator.

**Timely Enrollment**

Enrollment is “timely” if the completed enrollment form is received by the Plan Administrator no later than thirty (30) days after the person first becomes eligible for coverage, either initially or under a special enrollment period. If the enrollment form is not submitted within this deadline, the person will be a “late enrollee” and will have to wait until the next annual open enrollment period to enroll, unless that person experiences an event permitting mid-year enrollment (See Mid-Year Enrollment Changes).
Open Enrollment
The Plan includes an annual Open Enrollment period. Eligible employees failing to enroll when initially eligible can enroll as “late enrollees” during Open Enrollment without having to satisfy the special enrollment requirements. In addition, members may elect to make changes in their benefit selections during the Open Enrollment period. Changes in enrollment elections will become effective as of the first day of the plan year following the Open Enrollment period. Enrollment elections will remain in effect for the entire plan year and cannot be changed unless the employee experiences certain events that permit mid-year changes (See Mid-Year Enrollment Changes). Members who fail to make an election during Open Enrollment will automatically retain their present benefit elections. Annual Open Enrollment will take place during the month of April for a June 1st effective date.

Late Enrollment
An enrollment is “late” if it is not “timely” that is, if the enrollment is not completed within thirty (30) days after the person first becomes eligible to enroll or during a special enrollment period. Generally, late enrollees may enroll in the Plan only during Open Enrollment (See Open Enrollment above).

Special Enrollment
If an employee or the employee’s dependents are eligible but not already enrolled in the Plan, the employee may request “special enrollment” in the Plan upon either (1) the loss of other health plan coverage or (2) the addition of a new dependent as provided below:

1. Loss of Other Health Plan Coverage: An employee or a dependent who is eligible, but not enrolled in this Plan, may enroll if all of the following conditions are met:
   a. The employee or dependent was covered under another group health plan or had health insurance coverage at the time the individual first became eligible for coverage under this Plan.
   b. The employee stated in writing at the time Plan coverage was initially offered that the other health coverage was the reason for declining enrollment in this Plan, or the employee provided sufficient documentation of coverage under another plan at the time the initial decision to decline coverage was made.
   c. The other coverage of the employee or dependent ended because:
      ♦ The employee or dependent incurs a claim that will meet or exceed the overall annual maximum on all benefits. This right continues until at least thirty (30) days after the earliest date that a claim is denied due to the annual maximum.
      ♦ The employee or dependent is in a class of coverage that is no longer eligible under the terms of the other Plan.
   d. The employee submits a request for special enrollment in writing to the Plan Administrator no later than thirty (30) days after the date the other coverage terminates. Coverage will be effective no later than the first day of the month following the date the special enrollment request is received.

The above list is not an all-inclusive list of situations when an Employee or dependent loses eligibility. For situations other than those listed above see the Employer.

2. Newly-Acquired Dependents: An employee’s newly-acquired dependents may enroll in this Plan if:
   a. The employee is a participant under this Plan or, if not a participant at the time, the employee has met the waiting period applicable to becoming a participant and is eligible to be enrolled under this Plan; and
b. The person becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

If the employee is not yet a participant, the employee must enroll during the Special Enrollment Period in order for the newly acquired dependent to be eligible for coverage. In the case of birth or adoption of a child, the spouse of the covered employee may be enrolled as a dependent of the covered employee if the spouse is eligible for coverage.

The Special Enrollment Period is a period of not more than thirty (30) days that begins on the date of the marriage, birth, adoption, or placement for adoption.

The coverage of the employee or dependent enrolled during the Special Enrollment Period will be effective:
1. In the case of marriage, not later than the first day of the first month following the date that the completed request for enrollment is received by the Plan Administrator.
2. In the case of a dependent’s birth, as of the date of birth.
3. In the case of a dependent’s adoption or placement for adoption, the date of the adoption or placement for adoption.

The “enrollment date” for anyone who enrolls under a Special Enrollment Period is the first date of coverage.

**MID-YEAR ENROLLMENT CHANGES**

Once enrollment elections are made, either during the initial or Special Enrollment periods or during an annual Open Enrollment period, those elections may not be changed and will remain in effect for the entire plan year. However, there are some important exceptions:

1. **Change in Status**

   Employees may revoke or modify their enrollment elections mid-year only if they experience a Change in Status that affects their eligibility or the eligibility of their dependents under this Plan. A “Change in Status” is one of the following events:

   a. **Change in legal marital status**, including marriage, death of spouse, divorce, legal separation or annulment.

   b. **Change in number of dependents**, including birth, adoption, placement for adoption, and death of a spouse or other dependent.

   c. **A dependent satisfying or ceasing to satisfy the requirements for coverage**.

   d. **Change in employment status** of the employee, the employee’s spouse or other dependent, including termination or commencement of employment, taking or returning from an unpaid leave of absence, change in work site, change in full-time or part-time status, change in hourly or salaried status, change in dependent’s eligibility for other employer-based coverage.

   e. **Change in residence** by the employee, the spouse or dependent.

   An election change will be approved only if it is consistent with the Change in Status. An election change is “consistent with” a Change in Status if the change is both the result of and corresponds with the Change in Status. For example, if a child ceases to be eligible for coverage because of age, it would be consistent with the Change in Status to drop coverage for the child. However, it would not be consistent with the Change in Status to drop coverage for the employee. As another example, if a spouse is covered under the medical plan of the
spouse’s employer, and the spouse loses coverage under that plan because of a change from full-time to part-time employment, it would be consistent with the Change in Status for the employee to elect to add the spouse under this Plan.

2. **Change in Cost or Coverage**
   If the cost of benefits increases or decreases during a benefit period, the Plan Sponsor may automatically change employee premium contributions. When the change in cost is significant, employees will be given the opportunity to either increase their contributions or elect a less-costly option (if available).

   If there is a significant overall reduction in the Plan’s coverage, employees may elect another benefit option (if available). If a new benefit option is added under the Plan, employees will have the right to change their election to the new benefit option.

3. **Qualified Medical Child Support Order (“QMCSO”)**
   A QMCSO is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in custody that requires health coverage for an employee’s child. An employee may change his or her Plan enrollment elections if the employee becomes subject to a QMCSO that requires the employee to provide (or cancel) health care coverage for a child.

4. **Entitlement to Medicare**
   An employee may change his or her elections for Plan coverage if the employee or any dependent becomes entitled to or loses Medicare coverage.

5. **Entitlement to Medicaid or Children’s Health Insurance Coverage Reauthorization Act (CHIPRA)**
   An employee may change his or her elections for Plan coverage if the employee or any dependent becomes entitled to or loses Medicaid or CHIPRA.

Eligible employees enrolled in Medicaid or CHIPRA may enroll in the Plan by submitting a completed Enrollment Change form to the Plan Administrator within 60 days of loss of coverage.

**How to Make Mid-Year Enrollment Changes**
If an employee experiences an event that allows the employee to make a mid-year enrollment change, the employee must submit a completed Enrollment Change Form to the Plan Administrator no later than thirty (30) days after the event occurs. If the employee does not request the coverage change within the specified time limit, the employee will lose the right to make a change allowed by that event.

**How to Make Mid-Year Enrollment Changes for Medicaid or CHIPRA**
If an employee experiences an event that allows the employee to make a mid-year enrollment change, the employee must submit a completed Enrollment Change Form to the Plan Administrator no later than sixty (60) days after the event occurs. If the employee does not request the coverage change within the specified time limit, the employee will lose the right to make a change allowed by that event.

**Effective Date**
If approved, the employee’s enrollment change(s) will take effect:

1. On the date of the event, in the case of a birth, adoption or placement for adoption.
2. No later than the first day of the month following the date the Plan Administrator receives the employee’s completed Enrollment Change Form, in the case of all other enrollment changes.
TERMINATION OF COVERAGE

Rescission: Fraud and intentional misrepresentation of a material fact by employees or covered persons are prohibited. The Plan shall have the right to rescind coverage if a covered person performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of a material fact relating to health care or coverage. Thirty (30) days advance written notice will be provided to the person for whom coverage is being rescinded. An employee has the right to appeal a rescission of coverage (See Appeals section). A rescission is a cancellation or discontinuance of coverage that has a retroactive effect.

Employee Coverage Termination
Employee coverage will terminate on the earliest of the following dates:

1. The date following the last day for which premiums were paid when the covered employee terminates employment.
2. The date on which the covered employee ceases to be in a class eligible for coverage.
3. The date on which this Plan is terminated; or in case of any benefit under this Plan, the date of termination of the specific benefit.
4. The date the covered employee dies.
5. The date the covered employee enters the military service of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one (1) month in any calendar year.
6. The date the covered employee fails to make any required contribution for coverage.
7. The date on which a cancellation or discontinuance of coverage due to rescission is effective retroactively, as provided above.

NOTE: This Plan is not subject to COBRA because it is a “Church Plan”. However, other continuation provisions, not legally required, are outlined below.

Period of Continued Coverage
If you cease working because of sickness or injury, your Plan may provide for limited continuation. You should consult with your Adopting Institution for further details.

Coverage may also continue for the following periods:
1. **Leave of Absence.** The end of the period of approved leave of absence.
2. **Layoff.** The date six months after the end of the month in which layoff occurs.

A Member who qualifies may be eligible to continue benefits if active employment ends because they are completing their term as at least a nine but less than 12 month employee. The period of continuation will be the lesser of:

1. The date the Member resumes active employment as scheduled; or
2. Three months.

Members who continue coverage under this provision are not subject to a Waiting Period when active employment resumes immediately following this period.

Benefits Available
If you and/or your Dependents become Qualified Individuals at any time during which continuation applies to your Plan, medical benefits described in your booklet may be continued beyond normal termination dates.

A. **Qualified Persons/Qualifying Events**

Continuation of group health coverage will be offered to the following persons if they would otherwise lose that coverage as a result of the following events:
1. A Member (and any covered Dependents) following the Member's:
   (a) termination of employment for a reason other than gross misconduct; or
   (b) a reduction in work hours.

   (Note Taking a family or medical leave under the Federal Family & Medical Leave Act
   (FMLA) is not a qualifying event. A Member qualifies when the Member does not return
   to work after end of FMLA); and

2. A Member's former spouse (and any Dependent children) following a divorce or legal
   separation from the Member; and

3. A Member's surviving spouse (and any Dependent children), following the Member's death;
   and

4. A Member's Dependent spouse following loss of status as a Dependent under the terms of the
   Plan Document (e.g., attaining the maximum age, marriage, joining the armed forces, etc.);
   and

5. A Member's spouse (and any Dependent children) following the Member's entitlement to
   Medicare; and

6. A Member's Dependent child who is born to or placed for adoption with the Member who is on
   continuation due to termination of employment or reduction in work hours; and

7. If the Plan Document covers retired Members, a retired Member and his/her Dependents (or
   surviving Dependents) when retiree health benefits are "substantially eliminated" or
   terminated within one year before or after the employer files Chapter 11 (United States Code)
   bankruptcy proceedings.

B. Maximum Continuation Period

Following a qualifying event, health coverage can continue up to the maximum continuation
period. The maximum continuation period for a Member (and any Dependents) following a
termination of employment or reduction in work hours is 18 months. The maximum continuation
period for a Member's Dependent child that is born to or Placed for Adoption with the Member
while on continuation will extend to the end of the Member's maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request
an 11-month extension of continuation. The maximum continuation will be 29 months (see
Disabled Extension, Section D).

When a Member becomes entitled to Medicare before employment terminates or work hours are
reduced, the maximum continuation period for the Dependents will be the longer of:
1. 36 months dating back to the Member's enrollment under Medicare; or
2. 18 months from the date of the qualifying event (termination of employment or reduction in
   work hours).

The maximum continuation period for qualified Dependents following a qualifying event described
in A (2) through A (5) is 36 months.

If the Plan Document covers retired Members and the qualifying event is the employer's
bankruptcy filing, the following rules apply:
1. If the retired Member is alive on the date of the qualifying event, the retired Member and
   his or her spouse and Dependent children may continue coverage for the life of the retired
   Member. In addition, if the retired Member dies while covered, the spouse or Dependent
   children may continue coverage for an additional 36 months.
2. If the retired Member is not alive on the date of the qualifying event, his or her spouse may
   continue coverage to the date of his or her death.

C. Second Qualifying Events

If during an 18-month continuation period (or, 29 months for qualified persons on the disabled
extension), a second qualifying event described in A(2) through A(5) occurs, the maximum
continuation period may be extended for the qualified Dependents up to 36 months. That is,
following a second qualifying event, qualified Dependents may continue for up to a maximum of
36 months dating from the Member’s termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in A (2) through A (5), absent the first qualifying event, results in a loss of coverage for Dependents under the Plan. A Member’s Dependent child who is born to or placed for adoption with the Member who is on continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption.

D. Disabled Extension
Following a termination of employment or reduction in work hours, a qualified person (Member or Dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months. A Member’s Dependent child who is born or placed for adoption with the Member who is on continuation must be determined disabled by the Social Security Administration within 60 days after the date of birth or placement for adoption. The disabled extension also applies to each qualified person (the disabled person and any family members) who is not disabled and who is on continuation as a result of termination of employment or reduction in work hours.

The 11-month extension for all qualified persons will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled; or (b) the date continuation would normally end as outlined in Section E below.

Coverage Continuation During Family and Medical Leave
Regardless of the leave policies described elsewhere in this Plan, this Plan will at all times comply with the Family and Medical Leave Act of 1993 and applicable regulations issued by the Department of Labor.

An eligible employee who is the spouse, son, daughter, parent or “next to kin” (defined as the nearest blood relative) of an injured US Armed Services member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to a total of 26 work weeks of leave during a 12-month period to care for the service member. (In compliance with the Family and Medical Leave Act of 1993 and applicable regulations issued by the Department of Labor).

During any leave taken under the Family and Medical Leave Act (FMLA), the employer will maintain coverage under this Plan under the same terms and conditions as coverage which would have been provided if the covered employee had been continuously employed during the entire leave period. The employee will continue paying any required contributions during the leave.

If Plan coverage is discontinued during the FMLA leave (either upon the employee’s election or for failure to pay required contributions during the 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 had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent as the coverage that was in force when coverage was discontinued. For example, waiting periods will not be imposed unless they were in effect for the employee and/or the employee’s dependents when Plan coverage was discontinued for the period of leave.

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.

Employees on Military Leave: Employees entering into or returning from military service will have the rights mandated by the Uniformed Services Employment and Reemployment Rights Act (“USERRA”). These rights include up to twenty-four (24) months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee, and immediate coverage upon return from military service. These rights apply only to employees and their dependents covered under the Plan before active military service begins.
Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

**Termination of Dependent Coverage:** A dependent’s coverage will terminate on the earliest of these dates:
1. The date on which the covered dependent ceases to be an eligible dependent.
2. The date the covered employee’s coverage under this Plan terminates.
3. The date on which the covered employee ceases to be in a class eligible for dependent coverage.
4. The date this Plan is terminated; in the case of any covered dependent’s benefit under this Plan, the date of termination of such benefit.
5. The date the covered dependent enters the military service of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any calendar year.
6. The date the covered employee fails to make any required contribution for dependent coverage.

**Certificate of Creditable Coverage**
When coverage for an employee or dependent terminates, a certificate of creditable coverage will be mailed to the individual’s last known address. A certificate also will be provided if requested within twenty-four (24) months of the termination of coverage.
DEFINITIONS

Capitalized terms that are used in this Plan shall have the following defined meanings. The inclusion of any phrase or word below does not imply that coverage for the service or supply is provided under the Plan.

ACCIDENTAL INJURY
Accidental injury is an immediate, unforeseen event caused by an external trauma to the body of a covered person, which is unrelated either directly or indirectly to all other causes and which requires treatment by a physician.

AMBULATORY SURGICAL CENTER
An ambulatory surgical center is any licensed public or private establishment with an organized medical staff of physicians with permanent facilities that (i) is equipped and operated primarily for the purpose of performing surgical procedures; (ii) provides continuous service of physicians and registered professional nurses whenever a patient is in the facility, and (iii) which does not provide services or other accommodations for patients to stay overnight. Charges are covered only for facilities that are approved by the Joint Commission on Accreditation of Hospitals.

APPROVED CLINICAL TRIAL
An Approved Clinical Trial is a phase I, phase II, phase III or phase IV clinical trial for a qualifying individual that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:
1. A federally-funded or approved trial.
2. A clinical trial conducted under an FDA investigational new drug application.
3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

For purposes of Approved Clinical Trials, a qualifying individual is a member who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition; and either of the following applies:
1. The referring health care professional is an in-network provider and has concluded that the individual’s participation in such trial would be appropriate.
2. The member provides medical and scientific information establishing that the individual’s participation in such trial would be appropriate.

CLAIM
A claim is any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan’s procedures for making benefit claims.

CO-INSURANCE RATE
Co-insurance rate is the rate or percentage that the Plan pays for Covered Medical Expenses after the calendar year deductible and/or copay has been met, subject to any applicable maximums.

CONCURRENT CARE CLAIM
There are two types of Concurrent Care Claims:
1. A claim to extend coverage for a course of treatment beyond a previously approved period of time or number of treatments.
2. A claim regarding reduction or termination of coverage by the Plan before the end of a previously approved period of time or number of treatments.

CONTRACEPTIVES
Contraceptives can be a drug, chemical agent or device that prevents conception. Benefits are available for the following items, which require disbursement by a Physician or Physician’s
prescription: injectable contraceptives, contraceptive devices including, but not limited to, diaphragms and IUDs; transdermal contraceptives; and implantable contraceptives. Oral contraceptives are covered under the Prescription Drug benefit. Over-the-counter contraceptives are not covered.

COPAY OR COPayment
Copay is the amount that the covered person is required to pay directly to the Provider each time the covered person receives services. The copay is separate from and does not accrue towards the deductible or co-insurance limits. Copayments are required for certain Covered Expenses even if the deductible requirements have been met or the co-insurance limit has been reached.

COSMETIC SURGERY
Cosmetic surgery is a procedure performed primarily to preserve or improve appearance rather than to restore the anatomy and/or functions of the body that are lost or impaired due to an illness or injury.

COVERED MEDICAL EXPENSES
Covered medical expenses are expenses for medical care provided to an individual while covered under the Plan and for which coverage is available under the Plan (see the Schedule of Benefits and Covered Medical Expenses sections for listings). Benefits for Covered Medical Expenses are subject to all the terms, conditions and limitations of the Plan.

CUSTODIAL CARE
Custodial care refers to services and supplies, including room and board and other institutional services, which are provided to an individual, whether disabled or not, primarily to assist him in the activities of daily living. These services and supplies are classified as custodial care regardless of the practitioner or provider who prescribes, performs or recommends the services.

DEDUCTIBLE
Deductible is the “out-of-pocket” amount before co-insurance that a covered person must pay for certain Covered Expenses. The deductible is separate from copayments. Individual and family deductibles apply under this plan.

Family Deductible – The family deductible is satisfied when the sum of all deductible payments for covered family members meets the calendar year family deductible amount. Any covered charges incurred by any covered family member after the family deductible is satisfied will be paid at the co-insurance rate up to applicable plan limits for the remainder of the calendar year.

DENTAL SERVICES
Dental services are procedures involving the teeth, gums or supporting structures.

DURABLE MEDICAL EQUIPMENT
Durable medical equipment is a device that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is prescribed by a physician and appropriate for use in the home.

EFFECTIVE DATE
Effective date is the date on which an employee or dependent is covered by the Plan.

ELIGIBILITY DATE
Eligibility date is the date on which an employee or dependent becomes eligible to participate in the Plan.
EMERGENCY MEDICAL CONDITION
Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson possessing an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to place the health of the individual in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES
Emergency services, with respect to an emergency medical condition, includes (i) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and (ii) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient.

EMERGENCY ROOM PHYSICIANS
Emergency room physicians are physicians who provide emergency services located in hospitals or in minor emergency centers. Care by emergency room physicians is not given on an on-going basis, and emergency room physicians do not admit and follow patients when hospitalized. For the purposes of this Plan, emergency room physicians are not considered to be primary care physicians.

EMPLOYEE
Employee is any person who is employed by the Employer, excluding any leased employees, independent contractors, or contract employees. Individuals classified by the Employer as leased employees, independent contractors or contract employees shall be excluded from Plan participation even if they are subsequently determined to be common law employees by any court or government agency.

EMPLOYER
Employer is Schreiner University and any affiliates that participate in the Plan for the benefit of eligible employees.

ENROLLMENT DATE
Enrollment date is the first day of coverage or, if the Plan has a waiting period, the first day of the waiting period. The enrollment date for a late enrollee or any person who enrolls during a special enrollment period is considered to be the first date of coverage under this Plan.

EXPERIMENTAL OR INVESTIGATIONAL
A treatment (other than covered off-label drug use) will be considered to be experimental or investigational if any of the following conditions are met:

1. The treatment is governed by the Food and Drug Administration (FDA) and the FDA has not approved the treatment for the particular condition at the time the treatment is provided.
2. The treatment is the subject of on-going Phase I, II, III, or IV clinical trials as defined by the National Institute of Health, National Cancer Institute or FDA and is not an Approved Clinical Trial (see Definitions).
3. There is documentation in published U.S. peer-reviewed medical literature stating that further research, studies, or clinical trials are necessary in order to determine the safety, toxicity or efficacy of the treatment.
FACILITY
A Facility is a healthcare institution which meets all applicable state or local licensure requirements, and which includes, but is not limited to the following: hospitals, skilled nursing facilities, intermediate care facilities, ambulatory surgical centers, free standing dialysis facilities or lithotriptor centers.

FORMULARY DRUGS
Formulary drugs are specified alternative prescription drugs for specific brand name drugs. Formulary drugs have been reviewed for safety, quality, effectiveness, and cost. A list of the Plan’s formulary drugs is included in the member information packet. The formulary drug list is periodically reviewed and modified by a panel of physicians and pharmacists.

GENERIC DRUGS
“Generic drugs” is a term used for prescription drugs identified by their chemical name. When the patent has expired on a brand name drug, the FDA permits manufacturers other than the original developer to create a bioequivalent of the brand name drug and make it available to the public. Generally, more than one manufacturer will create the generic version, although in many cases the same pharmaceutical firm that produces the brand name drug also makes the generic version. This prompts competitive pricing of the generic version and usually results in a less expensive drug.

HOME HEALTH CARE
Home Health care is a formal program of care and treatment that is performed in the home of a person, is prescribed by a physician, and is prescribed in lieu of treatment in a hospital or skilled nursing facility or results in a shorter hospital or skilled nursing facility stay. The home health care program must be organized, administered, and supervised by a hospital or qualified licensed personnel under the medical direction of a physician.

HOSPICE
Hospice is an agency that provides counseling and medical services and may provide room and board for a terminally ill individual. Covered Hospice services must meet all of the following requirements:

1. It is licensed and has obtained any required state or governmental Certificate of Need approval.
2. It is under the direct supervision of a physician, has a nurse coordinator who is a registered nurse (R.N.) and provides service twenty-four (24) hours a day, seven (7) days a week.
3. It is an agency that has as its primary purpose the provision of hospice services.
4. It has a full-time administrator and maintains written records of services provided to the patient.

HOSPITAL
An institution is considered to be a hospital if it fully meets each of the following requirements:

1. It maintains on the premises, on an inpatient basis, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons, by or under the supervision of a staff of duly qualified physicians.
2. It continually provides on the premises twenty-four (24) hours a day registered nurse (R.N.) services.
3. It is recognized as a hospital by the Joint Commission on Accreditation of Hospitals.
4. It charges fees for its services.

The term "hospital" will not include, nor will the term "covered charges" include charges incurred in connection with confinement in any institution or part thereof used principally as a rest or nursing facility or a facility for custodial care. Facilities for the treatment of mental health disorders and substance use disorders must be licensed by the State Board of Health and approved by the Joint Commission on Accreditation of Hospitals.
ILLNESS
An Illness is a mental or physical disease or infirmity, including pregnancy or pregnancy-related conditions.

INJURY
An Injury is the accidental bodily harm to a covered employee or covered dependent.

IN-NETWORK PROVIDERS
An in-network provider is one who has elected to participate directly in the Plan or through a network supplementary to the Plan. A directory of in-network providers is available from the Plan Administrator. This Plan may reimburse differently based on whether the hospital/facility, physician, or other medical service provider participates directly in the Plan or through a network supplementary to the Plan.

MEDICALLY NECESSARY
Care and treatment is "medically necessary" if the Plan Administrator or its delegate determines that the care and treatment meets all of the following conditions:

1. It is recommended and provided by a licensed physician, dentist or other medical practitioner who is practicing within the scope of his or her licenses.
2. It is appropriate for the symptoms and is consistent with the diagnosis, if any. "Appropriate" means that the type, level and length of services and setting are needed to provide safe and adequate care and treatment.
3. It is generally accepted as the standard of medical practice and care for the diagnosis and treatment of the particular condition.
4. It is specifically allowed by the licensing statutes which apply to the provider who renders the service.
5. It is ordered and documented in a timely fashion in the covered person's medical record.
6. If an inpatient procedure, it could not have been adequately performed in an outpatient facility.
7. It is not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

The fact that a physician may prescribe, recommend, approve or view a service or supply, as medically necessary does not make that service or supply medically necessary under the Plan. The Plan Administrator has sole and complete discretionary authority to determine whether the service or supply is medically necessary as defined under the Plan and may seek assistance or guidance for its determination from the Medical Department of Healthgram, Inc.

MEMBER
Member is an employee or dependent that satisfies the requirements outlined in the Eligibility section and is enrolled in the Plan.

MENTAL HEALTH DISORDERS
A mental health disorder is a disease or condition, except those related to a substance use disorder, that is classified as a mental or nervous disorder in the current edition of Internal Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), U.S. Department of Health and Human Services Publication No. (PHS) 89-1260, or in any subsequent revision of the International Classification of Diseases published by the U.S. Government Printing Office.
OUT-OF-NETWORK PROVIDER
As outlined in the Schedule of Benefits, this Plan may reimburse differently based on whether the hospital, facility, physician or other medical service provider is contracted as a participating provider with the Plan or through an in-network provider network supplementary to the Plan. An “out-of-network provider” is one who has not elected to participate in the Plan or through an in-network provider network supplementary to the Plan. All charges by a out-of-network provider are subject to the Plan’s definition of Plan Allowance.

OUT-OF-POCKET LIMIT
Except for expenses expressly disallowed, the Out-of-Pocket Limit is the maximum amount that a covered person must pay for covered expenses during the calendar year. The Plan has individual as well as family annual out-of-pocket limits.

OUT-OF-AREA BENEFITS
Out-of-area benefits apply to members who reside in a location that does not offer access to a sufficient number or specialty of in-network providers. The Plan Administrator determines which members are covered through the out-of-area provision. Out-of-area benefits also apply to emergency care.

OUTPATIENT/REFERENCE DIAGNOSTIC LAB CHARGES
Charges incurred from independent freestanding reference labs and/or charges incurred on an outpatient basis from a hospital and/or facility.

PAIN THERAPY / PAIN MANAGEMENT
Pain therapy/pain management treatment includes but is not limited to epidural steroid injections, nerve blocks, pain center (facility) fees, and all other related professional services. This does not include services received as a result of malignancy.

PARTICIPATING PHARMACY
Participating pharmacy is any pharmacy licensed to dispense prescription drugs that is included as a participant in the program offering pre-paid benefits to eligible Plan participants.

PHYSICIAN
The term physician is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. For services covered by this Plan and for no other purpose, doctors of dental surgery, doctors of dental medicine, doctors of podiatry or surgical chiropody, chiropractors, optometrists, licensed psychologists, physical therapists, occupational therapists, speech therapists, physician assistants, nurse practitioners, licensed medical social workers, and midwives are deemed to be physicians when acting within the scope of their state licenses. Except as otherwise provided by state law, physician assistants, nurse practitioners (including Certified Registered Nurse Anesthetist also known as CRNA’s), and midwives must practice under the direct supervision of a physician (M.D. or D.O.). Physical, occupational and speech therapy must be prescribed by a physician (M.D. or D.O.). PhDs in psychology are also considered covered providers.

PLAN ADMINISTRATOR
Plan Administrator is the Plan Sponsor or the person or committee appointed by the Plan Sponsor to carry out the administration and management of the Plan. The Plan Administrator has sole and complete discretionary authority to interpret the Plan, including those provisions relating to eligibility and benefits due under the Plan, and to make all determinations, including factual determinations, arising under the Plan.
PLAN ALLOWANCE
The Plan Allowance is the amount that the Plan Administrator in its sole discretion, has determined to be the maximum amount payable for an out-of-network provider covered service. Charges in excess of the Plan Allowance will not be considered Covered Medical Expenses under this Plan. The Plan will reimburse the actual charge billed if it is less than the Plan Allowance. A complete listing of the Plan Allowance charges is located at www.healthgram.com. The Plan Allowance only applies to out-of-network providers (see Schedule of Benefits). This provision does not apply to Dental benefits. The Plan Administrator has the discretionary authority to decide whether a charge meets the Plan Allowance.

PLAN PARTICIPANT
Plan participant is an employee of the Employer who is covered under the Plan.

PLAN SUPERVISOR
Plan Supervisor is the person or firm employed by the Plan Sponsor to provide administrative services to the Plan including the processing and payment of claims.

POST-SERVICE CLAIM
Post-Service Claims are any claims filed for payment of benefits after medical care has been received.

PRE-SERVICE CLAIM
Pre-Service Claim is a claim for a benefit under this Plan when the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. For more information, see the Care Management Requirements section.

PRIMARY CARE PHYSICIAN (PCP)
A PCP is a physician specializing in internal medicine, general practice, family practice, pediatrics, and/or obstetrics or gynecology chosen by the covered person to manage the continuity of his or her medical care. Certified Physician’s Assistants (PAC’s) and Certified Nurse Practitioners (CNP’s) supervised by the primary care physician may also be considered PCP’s under the Plan as long as they practice in the same location as the PCP.

PRIMARY CARE SERVICES
The Plan encourages the selection of a primary care physician at the time of enrollment in the Plan. A primary care physician is a general internist, pediatrician, family physician or a gynecologist. The benefits listed in the Primary Care Services section apply only when provided in the office of a primary care physician. Plan Allowance limitations may apply. (See Schedule of Benefits)

RETIREMENT
Retirement begins on the first day on which retirement benefits become effective under:

1. Any plan of a federal, state, county, municipal or association retirement system for which the employee is eligible as a result of employment with the Employer.
2. Any plan which the Employer sponsors.
3. Any plan to which the Employer makes contributions or has made contributions.
4. The United States Social Security Act or any similar plan or act. If the employee is in active employment and is receiving disability benefits under the United States Social Security Act or any similar plan or act, the employee will not be considered retired.

SICKNESS
An illness or disease of a covered employee or covered dependent including congenital defects or birth abnormalities.
SKELETAL ADJUSTMENT
Skeletal Adjustment is the treatment of the skeletal system performed by external manipulation including, but not limited to, vertebral manipulation and associated adjunctive therapy.

SLEEP DISORDER
Sleep Disorders include but are not limited to sleep apnea, snoring, and narcolepsy.

SUBSTANCE USE DISORDER
A substance use disorder is the continued use or abuse of, and/or dependence on, legal or illegal substance(s), despite significant consequences or marked problems associated with the use as defined, described, or classified in the most current version of Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

TEMPOROMANDIBULAR JOINT SYNDROME (TMJ)
TMJ is an abnormal condition characterized by facial pain and by mandibular dysfunction usually caused by a defective or dislocated temporomandibular joint.

TRANSPLANT
See Organ Transplant Program under the Care Management Requirements section.

URGENT CARE CENTERS
An urgent care center is a public or private establishment that is equipped and operated primarily for the purpose of providing emergency treatment or performing surgical procedures and which does not provide services or other accommodations for patients to stay overnight. An urgent care center must be staffed by physicians and registered nurses.

URGENT CARE CLAIM
An Urgent Care Claim is any claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of the attending or consulting physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. A physician with knowledge of the claimant’s medical condition may determine if a claim is one involving urgent care. If there is no such physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson possessing an average knowledge of health and medicine may make the determination.
CARE MANAGEMENT REQUIREMENTS

The Plan features certain care management services designed to help ensure that all covered persons receive necessary and appropriate health care while avoiding unnecessary expenses when a hospital confinement, a surgical procedure or certain other care is proposed. Covered persons must use the services and follow all necessary steps as required. Failure to comply with these requirements will result in a 50% reduction of benefits and a penalty may apply.

Please note that the Plan is not directly involved in treatment, but only provides benefits for services that are covered under the terms of the Plan. Therefore, the Plan has no liability for the quality of care the member may receive. The member and health care provider(s) are responsible for making all decisions regarding health care and will control the course of treatment followed.

PRECERTIFICATION PROCESS

In order to receive full benefits for the services listed below, the covered person must obtain pre-certification prior to receiving the services or treatment. Pre-certification is the responsibility of the member. If the member is unsure whether pre-certification has been made, he or she should call to verify.

A seven (7)-day advance notice for precertification is required for the following:

- Ambulatory Surgery
- Chemotherapy/Radiation Therapy
- Durable Medical Equipment (rental or purchase)
- Home Health Care
- Hospice Care
- Inpatient Care in Extended Care Facilities
- Inpatient Care in Mental Health Residential and Treatment Centers
- Inpatient Rehabilitation Services
- Inpatient Care in Skilled Nursing Facilities
- Inpatient Care in Substance Residential and Treatment Centers
- Non-Emergency Hospital Admissions (including observation)
- Outpatient Surgery
- Pain Therapy (outpatient)
- Prosthetics

FOR PRE-CERTIFICATION CALL:
1-800-472-5001
8:30am—5:00pm EST
Monday through Friday

Hospital Admissions
For Emergency Admission: The covered person or an authorized representative of the family or the admitting office must call within forty-eight (48) hours or by the end of the first business day after admission.

For Non-Emergency Admission: The covered person or an authorized representative of the family or the admitting office must have the hospital/facility days certified by calling Healthgram, Inc.’s Medical
Department when planning a future admission for the covered person. This must be done at least seven (7) days before the scheduled date of admission.

Pre-certification is the ultimate responsibility of the covered person. If the member is unsure whether pre-certification has been made, he or she should call to verify.

**Pre-Certification Penalty**
See Schedule of Benefits.
If pre-certification is not obtained, benefits are reduced by 50% of the applicable rate.

Pre-Admission Certification is not a guarantee of either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to the terms of this Plan. If pre-certification is not obtained due to special circumstances and the member notifies the Plan Supervisor promptly of those circumstances, the applicable benefit reductions and penalties may be waived. Waivers will be applied in a consistent, nondiscriminatory manner to all similarly situated persons.

**UTILIZATION REVIEW**

When a hospital admission or other admission requiring pre-certification is recommended, the Plan Supervisor’s Medical Department must be contacted for utilization review.

**Information Needed for Review.** The following information will be needed for a review:

1. **Employee** name and **member number**.
2. **Employer’s** name.
3. **Patient’s** name and date of birth.
4. Name, address, and phone number of **admitting/attending physician**.
5. **Date** of hospital/facility admission.
6. **Hospital/facility** name, address, and phone number.

**Physician Contact**
The attending physician will be contacted as part of the precertification process to:

1. Discuss the admitting diagnosis and the procedure(s) to be performed.
2. Determine if an outpatient option applies and if the procedure(s) can/should be performed on an outpatient basis.
4. Agree upon the number of days in the hospital/facility for the specific procedure(s).

**Hospital/Facility Contact**
During the covered person’s inpatient stay, Healthgram, Inc.’s Medical Department will contact the hospital/facility as part of the pre-certification process in order to determine that:

1. The admission takes place upon the determined date and the prescribed care is being administered.
2. The patient is actually receiving the treatment outlined by the physician.
3. The patient is released from the hospital/facility when inpatient care is no longer needed.

**Inpatient Extension Process.** If, in the opinion of the patient’s physician, it becomes necessary to extend the stay, then the physician or the hospital/facility may request an extension of the certification by calling Healthgram, Inc.’s Medical Department. This must be done no later than on the last day that has already been certified.
Treatment Disagreements. When there is a disagreement between the Healthgram, Inc.’s medical review coordinator and the attending physician as to the length of stay, course of treatment, or any other medical need, the physician may proceed as he sees fit, although covered benefits could be affected. The attending physician always has control of all treatment issues once the patient is admitted to the hospital/facility. The role of the Plan Administrator and of the Healthgram, Inc. Medical Department in the utilization review process pertains solely to coverage under the terms of this Plan.

Pre-Admission Certification is not a guarantee of either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to the terms of this Plan. If pre-certification is not obtained due to special circumstances and the member notifies the Plan Supervisor promptly of those circumstances, the applicable benefit reductions and penalties may be waived. Waivers will be applied in a consistent, nondiscriminatory manner to all similarly situated persons.

CASE MANAGEMENT

If a covered person suffers an injury or illness for which healthcare needs are likely to be very complex and/or costs extremely high, the case may be referred for Case Management by the Plan Supervisor. After reviewing the case, the case manager may decide that an alternative plan of treatment is available. If an alternative plan of treatment is approved, benefits other than those described in this Summary Plan Description as Covered Medical Expenses may be payable if recommended by the case manager. Recommendations are made only on a prospective basis and only if the treatment is agreed to by the patient, the attending physician, and case management on behalf of the Plan. The Plan reserves the right to pay in-network benefits to any provider willing to enter into a negotiated arrangement through the Case Management program.

ORGAN/TISSUE TRANSPLANT PROGRAM

The Plan covers certain organ transplant procedures when a covered person is the recipient of the organ. In order to receive full benefits, the following requirements must be met:

1. The procedure must be precertified and arranged through Case Management by calling the Plan Supervisor at 1-800-472-5001.
2. The procedure must be performed at an approved facility or hospital.

Failure to meet these requirements will result in reduced benefits. The coinsurance rate will be 50% with a maximum benefit of $100,000, the out-of-pocket limit will not apply, and the additional covered benefits listed below will not apply.

Eligible charges incurred by the covered person will be paid for donor expenses directly related to the procurement of a living or cadaver human organ for any covered transplant procedure.

Charges incurred for organ transplant surgery will be paid for the following organ transplant categories to allow for reasonable and medically necessary care and treatment. All other organ transplants not specifically mentioned here will be excluded and no benefits will be paid for any charges associated with them. Covered organ transplant categories are bone marrow, heart, lung, kidney, pancreas, liver, peripheral stem cell.

Covered Medical Expenses will include use of temporary life-support equipment pending the acquisition of “matched” human organs, multiple transplants during one operative session, replacement(s) or subsequent transplant(s), follow-up expenses for covered services (including immuno-suppressant therapy). Non-covered expenses will include any financial consideration to a
donor other than expenses directly related to the performance of the surgery, any animal organ or mechanical organ, anything excluded or limited as stated in the Plan.

Additional covered benefits include:


Reimbursement for travel and lodging expenses incurred during the transplant procedure immediately prior to and after the transplant up to a $10,000 maximum for the covered person and a companion. Travel and lodging discounts are also available with select airlines and hotels.
COORDINATION OF BENEFITS

Coordination of Benefits
When two (2) or more plans cover the incurred expenses, coordination of benefit rules will apply to determine the order in which those plans pay for covered charges. When a covered person is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the coordination rules is the primary plan and will pay as if there were no other plan involved. When this Plan is secondary, the Plan will pay the lesser of the patient liability under the primary plan or the allowable charges the Plan would pay if primary.

Generally, unless a specific rule applies, where a claim is submitted for payment under this Plan of Benefits and one or more other Plans, this Plan of Benefits is the Secondary Plan.

Benefit Plan
The Plan will coordinate medical and dental benefits provided under another benefit plan. The term “benefit plan” may include any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Group practice and other group pre-payment plans.
3. Federal government plans or programs, including Medicare, Medicaid and CHIPRA.
4. Other plans required or provided by law.
5. No fault auto insurance, by whatever names it is called, when not prohibited by law.

Allowable Charges
For a charge to be allowable it must be a Plan Allowance charge (see Definitions) and at least part of it must be covered under this Plan.

In the case of health maintenance organization (HMO) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. In addition, 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 service 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.

When coverage of medical expenses is available under an automobile insurance policy, coverage under this Plan is limited to covered expenses in excess of those available under the automobile insurance policy, without reimbursement for any deductibles under the automobile insurance policy. This Plan always shall be the secondary plan regardless of the individual’s election under PIP (personal injury protection) coverage with the automobile insurance carrier.

When coverage of medical expenses is available under a non-group (individual) comprehensive medical insurance policy, coverage under this Plan shall always be secondary.

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 coordination provisions will pay first. Plans with coordination provisions will be considered after those without them.
2. Plans with coordination provisions will pay benefits in accordance with the following rules, whichever applies first, up to the allowable charge:
(a) The plan that covers the person directly, as an employee, member, or subscriber, (Plan A) pays before the plan that covers the person as a dependent (Plan B).

**Special Rule.** If (i) the person covered directly is a Medicare beneficiary and (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) A plan which covers a person as an employee who is neither laid-off nor retired (or as a dependent of such employee) pays before a plan which covers that person as a laid-off or retired employee (or as a dependent of such laid-off or retired employee). If the other benefit plan does not have this rule, and if, consequently, the plans do not agree on the order of benefits, this rule does not apply.

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

   (i) The plan of the parent whose birthday falls earlier in a year pays before the plan of the parent whose birthday falls later in that year; and

   (ii) If both parents have the same birthday, the plan that has covered the patient for the longer time pays before the plan that covers the other parent.

(d) When a child is covered as a dependent and the parents are divorced or legally separated, these rules will apply:

   (i) If there is a court decree that establishes that one parent is financially responsible for the health care expenses of the child, the plan of that parent will be considered before other plans that cover the child as a dependent.

   (ii) If there is a court decree that states that the parents share joint custody of the child without stating that one of the parents is financially responsible for the child’s health care expenses, then the plans will apply the birthday rules outlined under (d) above to determine which plan is primary.

   (iii) If there is no court decree, then:

       (a) If the parent with custody of the child has not remarried, the plan of the parent with custody will pay before the plan of the parent without custody.

       (b) If the parent with custody of the child has remarried, the plan of the parent with custody will be considered first. The plan of the stepparent that covers the child as a dependent will be considered next. The plan of the parent without custody will be considered last.

(e) If there is still a conflict after these rules have been applied, the plan that has covered the patient for the longer time will be considered primary.

3. Medicare will pay primary, secondary, or last to the extent required by 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 in both of these parts.

**Right to Receive or Release Necessary Information.** This Plan may give or obtain needed information from another insurer or any other organization or person for purposes of coordinating benefits. This information may be given or obtained without the authorization of or notice to the person that is the subject of the information. When a claim for benefits is filed, information must be provided regarding any other plans which also cover those claims.
Facility of Payment. This Plan may repay other plans for benefits paid by the other plans that the Plan Administrator determines should have paid by this Plan. 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 from the covered person. That repayment will count as a valid payment under the other benefit plan. In addition, this Plan may pay benefits that are later determined 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.

PLEASE NOTE: If other health coverage is available from any other source that provides for coordination, amounts paid by the Plan do not accrue toward the out-of-pocket limit.
THIRD PARTY RECOVERY

Rights of Reimbursement and Subrogation
The Plan does not cover expenses for which another party(ies) may be responsible as a result of liability for causing or contributing to the injury or illness of you and your Dependent(s). While such expenses are not covered under this Plan, the Plan may advance payments for such expenses. As a condition to the Plan advancing payments for any condition or injury for which another party may be responsible, the covered person shall agree to reimburse the Plan in full, and in first priority, from any funds recovered from any responsible party, (which may be an individual, a company or an insurer).

The amount to be reimbursed to the Plan will equal the payments advanced by the Plan, without any adjustment for the covered person's attorney fees and costs to obtain payment from the responsible party, but will not exceed the amount received from the responsible party. The Plan's rights shall not be subject to reduction under any common fund or similar claims or theories.

The Plan shall automatically have a first priority lien upon the proceeds of any recovery from a third party as the result of a judgment, settlement, or otherwise, by or on behalf of a covered person. Such proceeds shall be deemed to be held in trust for the benefit of the Plan until reimbursement, to the extent of the payments advanced by the Plan. Any funds recovered from the third party shall be applied first to reimburse the Plan for any and all payments made under the Plan for that covered person, regardless of the following:

1. The amount of damages claimed by the covered person against the third party or whether the covered person has been made whole for such damages.
2. Any characterization of the payments by the third party with respect to the covered person's damages, such as personal injuries, future education or training or, pain and suffering.
3. The covered person recovering the funds or property being a minor.

If the covered person receives funds from the third party and does not promptly reimburse the Plan, future benefits may be reduced to cover the amount of payments advanced by the Plan.

In addition to the right to reimbursement, if the Plan advances payments for a condition or injury that another party is responsible for paying, the Plan will be subrogated to the covered person’s right to recover from the third party. This means that the Plan may assume the rights of the covered person to file a lawsuit or make a claim against the party whose acts or omissions caused the condition or injury.

The Plan Administrator may in its sole and complete discretion determine whether or not to pursue the Plan's right of subrogation.

The Plan’s right of full recovery may be from the third party, and liability or other insurance covering the third party, malpractice insurance; the Member’s own uninsured motorist insurance, underinsured motorist insurance, any medical payment (Med-Pay), no fault, personal injury protection (PIP); or, any other first or third-party insurance coverages which are paid or payable. The Plan’s right of recovery shall not be subject to reduction under any common fund or similar claim or theories.

Pursuing Reimbursement and Subrogation
These rights of reimbursement and subrogation are reserved whether the liability of a third party arises in tort, contract or otherwise. As a condition to receiving payments from the Plan, covered persons shall agree to fully assist and cooperate with the Plan Administrator in protecting and obtaining the Plan’s reimbursement and subrogation rights, including, but not limited to, promptly
furnishing the Plan Administrator with information concerning the person’s right of recovery from any third party, and, if requested, executing and returning any reimbursement or subrogation-related documents. The covered person shall further agree not to allow the Plan’s reimbursement and subrogation rights to be limited or prejudiced by any acts or omissions by the covered person. In the event of any such acts or omissions by the covered person, the Plan Administrator shall be authorized in its sole discretion to suspend or terminate the payment or provision of any further benefits to or for the benefit of the covered person.

Please Note: If an attorney is obtained, the Plan may require him/her to complete a subrogation agreement to reimburse the Plan 100% before payments are advanced.
FILING CLAIMS

CLAIM FILING PROCEDURE

It is the responsibility of the covered person to see that doctor bills, medical bills, and hospital charges are submitted to the Plan Supervisor. Claim forms may be obtained from the Human Resources office, or they can be found online at www.healthgram.com/forms. Claim forms must be filled out completely. Claims must be submitted to the Plan Supervisor at:

Healthgram, Inc., Inc.
Attention: Claims Department
PO Box 11088
Charlotte, North Carolina 28220-1088
(704) 523-2758

Benefits are paid to the employee/covered person unless the provider agrees to accept the payment directly or there is a valid assignment of the right to receive payment permitted under the terms of the Plan. The following items are important and should be submitted with each claim.

1. If a provider has not completed a billing statement form, the covered person must obtain a claim form from the Human Resources Office for completion.
2. All provider bills must include the following:
   a. Name of patient.
   b. Date, description and charge for each service.
   c. A complete and accurate diagnosis.
   e. Provider’s Federal ID Number or social security number.
   f. Complete current address of physician, including zip code and telephone number.
3. Claims for medication or drug expenses must include the following:
   a. Name of person for whom drug was prescribed.
   b. Prescription number and name of drug.
   c. Cost of medication and date of purchase (cash receipts, canceled checks, or credit card receipts cannot be accepted for consideration).
   d. Name of physician prescribing drug.
   e. For generic drugs, the prescription receipt marked GENERIC by pharmacist.
4. Copies of all other covered charges, such as for registered nurses and supply houses, must include the following:
   a. Name of patient.
   b. Date and charge for visit(s).
   c. Nature of treatment or services rendered.
   d. Federal ID Number or social security number of provider.
   e. Complete diagnosis.

Report claims promptly. The deadline for filing a claim for any benefit is twelve (12) months after the date that the expense is incurred. If the covered person fails to file a claim within this time period, the claimed expenses will not be covered under the Plan.
INITIAL CLAIMS PROCESSING

Following is a description of how the Plan processes claims for benefits. A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan’s procedure for making benefit claims, as described here.

There are different kinds of claims and each one has a specific timetable for approval, payment, denial, or request for further information. For questions regarding the claims procedure, please contact the Plan Supervisor.

Post-Service Claims
Post-Service Claims are those filed for payment of benefits after medical care has been received. If a Post-Service Claim is denied, the Plan Supervisor will provide written notification not later than thirty (30) days after receipt of the claim, if all needed information was provided with the claim. Sometimes additional time is necessary to process a claim due to circumstances beyond the control of the Plan. If an extension is necessary, the Plan Supervisor will provide written notification within the thirty (30) day period of the reasons for the extension and the date by which it expects to render a decision. The extension generally will be no longer than fifteen (15) days, unless additional information is needed.

If the extension is necessary because the claimant failed to provide all needed information, the notice of extension will describe the additional information required. The additional information must be provided within forty-five days. If all the needed information is received within that time limit and the claim is denied, the Plan Supervisor will provide notification the denial within fifteen (15) days after the information is received. If the needed information is not received within the forty-five (45) day period, the Plan Supervisor may decide the claim without that information.

A notification of denial will include:
1. The date of service, the health care provider, and the claim amount (if applicable).
2. The specific reason(s) for the denial, including the denial code and its corresponding meaning, and a description of the Plan’s standard, if any used in denying the claim.
3. A statement that diagnosis and treatment codes and their corresponding meanings will be provided upon request and free of charge.
4. Reference to the specific Plan provisions on which the determination is based.
5. A description of any additional material or information necessary to perfect the Claim and an explanation of why such material or information is necessary.
6. A description of the Plan’s appeal procedures, including the right to request an external review, and a statement of the right to bring a civil action under federal law following the denial of an appeal.
7. A statement disclosing any internal rule, guideline, protocol, or similar criterion referenced in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request).
8. If the denial is based on a medical necessity or experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefits determination (or a statement that such explanation will be provided free of charge upon request).
9. A statement regarding the availability of language assistance, as applicable.
10. Contact information for consumer assistance for the EBSA and state agencies.

Pre-Service Claims
Pre-Service Claims are those claims that require notification or approval prior to receiving medical care (for example, non-emergency hospitalizations and surgery). If a Pre-Service Claim is submitted properly with all needed information, the Plan Supervisor will send notification of the benefit determination, whether adverse or not, no later than fifteen (15) days from receipt of the claim.
If a Pre-Service Claim is not filed in accordance with the Plan's procedures, the Plan Supervisor will send notification of the improper filing, and how to correct it, within five (5) days after the improper claim is received.

If an extension is necessary to process your Pre-Service Claim, the Plan Supervisor will send written notification within the initial fifteen (15) day response period, and may request a one-time extension of up to fifteen (15) days. If the extension is necessary because additional information is needed, the notice of extension will describe the additional information required. The additional information must be provided within forty-five (45) days. If all the needed information is received within that time limit, the Plan Supervisor will provide written notification of the determination within fifteen (15) days after the information is received. If the needed information is not provided within the forty-five (45) day period, the Plan Supervisor may decide the claim without that information.

A denial notification will include the information listed here for Post-Service Claim details.

**Urgent Care Claims**

Urgent Care Claims are those that require pre-certification prior to receiving medical care, and where a delay:

1. Could seriously jeopardize life or health or the ability to regain maximum function.
2. In the opinion of the attending physician with knowledge of the member’s medical condition, could cause severe pain.

If an Urgent Care Claim is filed in accordance with the Plan’s procedures and include all needed information, the Plan Supervisor will provide notice of the determination, whether adverse or not, as soon as possible, but no later than seventy-two (72) hours after receipt of the Urgent Care Claim. If, however, the Plan’s procedures are not followed; the Plan Supervisor will provide notice of the improper filing and how to correct it within twenty-four (24) hours of receipt of the improper claim. This notification may be oral, unless the member requests a written notification.

If the claimant fails to provide all the information required to decide the claim, the Plan Supervisor will provide notice of the additional information needed within twenty-four (24) hours after receipt of the claim. The requested information must be provided within forty-eight (48) hours. The Plan Supervisor will provide notice of the determination on the claim no more than forty-eight (48) hours after the earlier of the following:

1. The Plan Supervisor’s receipt of the requested information.
2. The end of the forty-eight (48) hours given to provide the requested information.

A denial of an Urgent Care Claim will include the information listed here for Post-Service Claim denials. Notifications regarding Urgent Care Claim determinations may be oral, with written or electronic confirmation to follow within three (3) days.

**Concurrent Care Claims**

There are two types of Concurrent Care Claims:

1. A claim to extend coverage for a course of treatment beyond a previously approved period of time or number of treatments.
2. A claim regarding reduction or termination of coverage by the Plan before the end of a previously approved period of time or number of treatments.
A request to extend an ongoing course of treatment must be submitted at least twenty-four (24) hours before the end of the previously approved limit. If a request for extension is made timely and involves Urgent Care, the Plan Supervisor will provide notification of the determination, whether adverse or not, within twenty-four (24) hours after the claim is received. If the claim is not made at least twenty-four (24) hours prior to the end of the previously approved limit, the request will be treated as an Urgent Care Claim (not a Concurrent Care Claim) and decided according to the timeframes described here for Urgent Care Claims. A request to extend coverage that does not involve urgent care will be considered a new claim and will be decided according to the Post-Service or Pre-Service timeframes described here, as applicable.

If an ongoing course of treatment previously approved by the Plan is denied for continued coverage, the Plan Supervisor will provide notice sufficiently in advance to allow for an appeal.

Notices regarding denials of Concurrent Care Claims will include the information listed for Post-Service Claim denials.

Questions About Claim Determinations
Questions or concerns about a determination on your claim, contact the Plan Supervisor to inquire about it. This often clears up questions about benefit determinations, what the Plan covers, or what services were actually provided. The Plan Supervisor can be reached by calling the telephone number on the ID card or by writing to the address indicated above. A representative of the Plan Supervisor’s Claims Department will be available to answer questions about the claim. If the Plan Supervisor cannot resolve the issue satisfactorily, a formal appeal may be made as described below. Remember that a member is not required to contact the Plan Supervisor informally. If the claimant is not satisfied with a benefit determination, it may be appealed immediately.
This Plan offers a two-level appeals procedure.

**NOTE:** To appeal an Urgent Care Claim denial, please refer to the Urgent Care Appeals section below and call the Plan Supervisor immediately at the number indicated on the ID card.

**How to File a Level One Appeal**
A level one appeal is made to the Plan Supervisor in order to verify that the claim was processed properly and free of mechanical or factual error. Except for appeals involving Urgent Care (See Urgent Care Appeals), to appeal the initial denial of a claim, a request for appeal must be submitted in writing to the Plan Supervisor at the address indicated below:

Healthgram, Inc., Inc.
Post Office Box 11088
Charlotte, NC 28220

A level one appeal must be filed within one hundred eighty (180) days of receipt of the notice of denial. Comments, documents, and other information may be submitted in support of the claim. A member may review the claim file and present evidence and testimony. The review on appeal will consider any information submitted, even if it was not submitted for or considered as part of the initial determination. Also, upon request and free of charge, reasonable access to and copies of all documents, records, and information that are relevant to the claim will be provided. Any new or additional evidence considered, relied upon, or generated by the Plan, and any new rationale relied upon by the Plan, will be provided within a time frame sufficient to allow claimant to respond.

A document, record, or other information shall be considered relevant to a claim if it:
1. Was relied upon in making the benefit determination.
2. Was submitted, considered, or generated in the course of making the benefit determination.
3. Demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants.
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

**Determinations on a Level One Appeal**
The review on appeal will afford no deference to the initial benefit determination. Someone other than the individual involved in the initial benefit determination, not a subordinate of that individual, will be appointed to decide the appeal.

If the claim was denied based on a medical judgment (such as whether a service or supply is Medically Necessary, Experimental or Investigational), the Plan Supervisor will consult with a health professional with appropriate training and experience. The health care professional consulted for the appeal will not be a professional (if any) consulted during the initial determination or a subordinate of that professional. The Plan Supervisor also will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, even if the advice was not relied upon in making the benefit determination.
The Plan Supervisor will provide written or electronic notification of the determination on appeal as follows:

1. For level one appeals of pre-service claims, no later than fifteen (15) days after receipt of the appeal.
2. For level one appeals of post-service claims, no later than thirty (30) days after receipt of the appeal.

If the appeal is denied, the notification will include:

1. The date of service, the health care provider and the claim amount (if applicable).
2. The specific reason(s) for the denial, including the denial code and its corresponding meaning and a description of the Plan’s standard, if any, used in denying the claim.
3. Reference to the specific Plan provisions on which the determination is based.
4. A statement that the member entitled to receive, upon request and free of charge, reasonable access to or copies of all documents, records, or other information relevant to the claim, including the diagnosis and treatment codes and their corresponding meanings.
5. A statement of the appeals procedures offered by the Plan, including the right to request an external review, and a statement of the right to bring civil action under Federal law.
6. A statement disclosing any internal rule, guideline, protocol, or similar criterion referenced in making the adverse determination (or a statement that such information will be provided free of charge upon request).
7. If the denial on appeal is based on a medical necessity or experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefits determination (or a statement that such explanation will be provided free of charge).
8. A statement regarding the availability of language assistance, as applicable.
9. Contact information for consumer assistance for EBSA and state agencies.

**How to File a Level Two Appeal**

Except for appeals involving Urgent Care (See Urgent Care Appeals), a level two appeal must be submitted in writing to the Plan Administrator at the address indicated below:

c/o Healthgram, Inc., Inc.
Post Office Box 11088
Charlotte, NC 28220

A level two appeal must be filed within ninety (90) days of the receipt of the level one appeal denial. Comments, documents, and other information may be submitted in support of the claim. A member may review the claim file and present evidence and testimony. The review of the level two appeal will consider any information submitted, even if it was not submitted for or considered as part of the initial determination or level one appeal. Also, upon request and free of charge, reasonable access to and copies of all documents, records, and information that are relevant to the claim and level one appeal will be provided. Any new or additional evidence considered, relied upon, or generated by the Plan, and any new rationale relied on by the Plan, will be provided within a time frame sufficient to allow claimant to respond.

A document, record, or other information shall be considered relevant to a claim if it:

1. Was relied upon in making the benefit determination.
2. Was submitted, considered, or generated in the course of making the benefit determination.
3. Demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants.

4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

**Determinations on a Level Two Appeal**

The review on the level two appeal will be made by the Plan Administrator, and will afford no deference to the initial benefit determination and level one appeal. Someone other than the individual involved in the initial benefit determination and level one appeal, not a subordinate of either individual, will be appointed by the Plan Administrator to decide the appeal.

If the claim and appeal was denied based on a medical judgment (such as whether a service or supply is Medically Necessary, Experimental or Investigational), the Plan Administrator will consult with a health professional with appropriate training and experience. The health care professional consulted for the appeal will not be a professional (if any) consulted during the initial determination and the level one appeal or a subordinate of that professional. The Plan Administrator also will identify any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, even if the advice was not relied upon in making the benefit determination.

The Plan Administrator will provide written or electronic notification of the determination on appeal as follows:

1. For level two appeals of pre-service claims, no later than fifteen (15) days after receipt of the appeal.
2. For level two appeals of post-service claims, no later than thirty (30) days after receipt of the appeal.

If the level two appeal is denied, the notification will include:

1. The date of service, the health care provider and the claim amount (if applicable).
2. The specific reason(s) for the denial, including the denial code and its corresponding meaning and a description of the Plan’s standard, if any, used in denying the claim, and a discussion of the decision.
3. Reference to the specific Plan provisions on which the determination is based.
4. A statement that the member is entitled to receive, upon request and free of charge, reasonable access to or copies of all documents, records, or other information relevant to the claim, including diagnosis and treatment codes and their corresponding meanings.
5. A statement of the appeal procedures offered by the Plan, including the right to request an external review and a statement of the right to bring civil action under Federal law.
6. A statement disclosing any internal rule, guideline, protocol, or similar criterion referenced in making the adverse determination (or a statement that such information will be provided free of charge upon request).
7. If the denial on appeal is based on a medical necessity or experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefits determination (or a statement that such explanation will be provided free of charge).
8. A statement regarding the availability of language assistance, as applicable.
9. Contact information for consumer assistance for EBSA and state agencies.
Urgent Care Appeals
An appeal involves Urgent Care and requires immediate action if a delay could significantly increase the risk to the member’s health or impair the ability to regain maximum function or, in the opinion of a physician with knowledge of the member’s condition, could cause severe pain.

If an appeal involves Urgent Care, the appeal does not need to be submitted in writing. The member or physician should call the Plan Supervisor immediately at the number indicated on the ID card. The Plan Supervisor will provide notice of the determination on the appeal as soon as possible, but not later twenty-four (24) hours after receipt of the appeal. The notification may be written or electronic and will include the information described here for other appeal denials.

Voluntary Level of Appeal
The Plan offers a voluntary level of appeal that may include mediation or arbitration. Claimants may submit a benefit dispute to this voluntary appeal only after exhaustion of the appeals process described in the Appeals section.

If the claimant elects the voluntary level of appeal, any statute of limitations or other defense based on timeliness will be tolled during the time the voluntary appeal is pending. In addition, the Plan shall not assert that a claimant has failed to exhaust administrative remedies by not electing to submit the benefit dispute to the voluntary appeal provided by the Plan.

The Plan will provide to the claimant, upon request and at no cost, sufficient information about the voluntary appeal process to enable the claimant to make an informed judgment on whether or not to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant’s rights to any other benefits under the Plan, will list the rules of the appeal, will state the claimant’s right to representation, will enumerate the process for selecting the decision maker, and will give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be so informed.

How to Request an External Review
External review is not available to resolve disputes about eligibility other than those disputes that are related to rescissions.

1. Request for external review
   A claimant or authorized representative (“claimant”) may file a written request for an external review after receipt of notice of a final internal adverse benefit determination. The request for review must be submitted in writing to the Plan Administrator at the address indicated below:

   c/o Healthgram, Inc.
   Post Office Box 11088
   Charlotte, NC 28220

   The request must be filed within four (4) months after the date of receipt of a notice of a final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

2. Preliminary review
Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether all of the following conditions are met:

a. The claimant is or was covered under the Plan at the time the healthcare item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the healthcare item or service was provided.

b. The adverse benefit determination or the final adverse benefit determination involves (1) medical judgment, as determined by the external reviewer; or (2) a rescission of coverage.

c. The claimant has exhausted the Plan's internal appeal process.

d. The claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for ineligibility and contact information for the Employee Benefits Security Administration (EBSA) (toll-free number 866-444-3272). If the request is not complete, the claimant must submit the additional information within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

3. **Referral to Independent Review Organization**

   The Plan will assign an independent review organization (IRO) that is accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review.

4. **Review by IRO**

   a. The IRO will utilize legal experts where appropriate to make coverage determinations under the plan.

   b. The IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. Within ten business days following the date of receipt of such notice, the claimant may submit in writing additional information that the IRO must consider.

   c. Within five (5) business days after the date of assignment of the IRO, the Plan will provide to the IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination.

   d. Upon receipt of any information submitted by the claimant, the IRO will, within one (1) business day, forward the information to the Plan. The Plan may reverse its prior decision upon consideration of the additional information. The Plan will provide notice of such reversal to the IRO and the claimant, and the IRO will terminate the external review upon receipt of such notice.

   e. The IRO will consider the following in reaching a decision:

      i. The claimant's medical records.
      ii. The attending healthcare professional's recommendation
      iii. Reports from appropriate healthcare professionals and other documents submitted by the Plan, claim or the claimant's treating provider.
      iv. The terms of the Master Plan Document and SPD.
v. Appropriate practice guidelines.
vi. Any applicable clinical review criteria developed and used by the Plan.

vii. The opinion of the IRO's clinical reviewer.

5. **Notice of Final External Review Decision**
   a. The IRO will provide written notice to the Plan and claimant of the final external review decision within 45 days after receipt of the request for external review.
   b. The IRO decision notice will contain:
      i. A general description of the claim, including the date of service, the healthcare provider, the claim amount, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial.
      ii. The date the IRO received the assignment to conduct the review and the date of the IRO decision.
      iii. Reference to the evidence or documentation considered in reaching its decision.
      iv. A discussion of the principle reason(s) for its decision.
      v. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the claimant.
      vi. A statement that judicial review may be available to the claimant.
      vii. Current contact information for the EBSA (1-866-444-3272).

How to File an Expedited External Review

1. **Request for expedited external review**
   A Claimant may make a request for an expedited external review at the time the claimant receives either of the following:
   a. An adverse benefit determination that involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or the ability to regain maximum function and the claimant has filed a request for an expedited internal appeal.
   b. A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of an external review would seriously jeopardize the life or health of the claimant or the ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or healthcare item or service for which the claimant received emergency services, but has not been discharged from a facility.

2. **Preliminary Review**
   Using the standards set forth above for external review, the Plan will, immediately upon receipt of the request for expedited external review, determine whether the request meets the reviewability requirements and will immediately provide notice of its determination to the claimant.

3. **Referral to IRO**
   Using the standards and procedures set forth above for external review, the Plan will assign an IRO and transmit all necessary documents and information by any
available expeditious method. Using the standards and procedures set forth above for external review, the IRO will review the claim and reach a decision.

Notice of Final External Review Decision
Using the standards and procedures set forth above for external review, the IRO will provide notice of the final external review decision as expeditiously as the claimant’s medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the request for a expedited external review. If the notice is not in writing, the IRO will provide written confirmation of the decision in writing within forty-eight (48) hours after the date of providing that notice.
RESPONSIBILITIES FOR PLAN ADMINISTRATION

Plan Administrator. The Plan Sponsor may appoint an individual or a committee to serve as Plan Administrator of the Plan. If the Plan Administrator resigns, dies, or is otherwise removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

If the Plan Sponsor does not otherwise appoint a Plan Administrator, the Plan Sponsor shall be the Plan Administrator.

The Plan Administrator is required to administer this Plan in accordance with its terms and has the authority to establish policies and procedures for the management and operation of the Plan. It is the express intent of this Plan that the Plan Administrator shall have sole and complete discretionary authority to construe and interpret the terms and provisions of the Plan, to decide issues regarding eligibility and benefits due under the Plan, and to make all determinations, including factual determinations, arising under the Plan. Except as otherwise required by law, the decisions of the Plan Administrator will be final and binding for all interested parties.

Duties of the Plan Administrator. The Plan Administrator’s duties include:

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.
3. To settle disputes which may arise relative to a participant’s or beneficiary’s rights.
4. To prescribe procedures for filing claims for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a claims administrator to process and pay 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 Section 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 from the Plan Sponsor. However, all administrative expenses of the Plan, including compensation for services contracted from third parties in connection with the Plan, will be paid by the Plan Sponsor.

Fiduciary. A fiduciary is anyone who (i) exercises discretionary authority or control over the management of the Plan or the management and disposition of Plan assets; (ii) renders investment advice to the Plan; or (iii) has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties. A fiduciary must carry out his or her duties and responsibilities solely in the interest of participants and beneficiaries as follows:

1. For the exclusive purpose of providing benefits to employees and their dependents and defraying reasonable expenses of administering the Plan.
2. With the 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.
3. In accordance with the Plan documents to the extent that they are consistent with ERISA.

The Named Fiduciary. A “named fiduciary” is the Plan Administrator. The named fiduciary can appoint others to carry out fiduciary responsibilities other than as Plan trustees. These other persons become fiduciaries themselves and have fiduciary responsibility for their acts under the Plan. To the extent that the named fiduciary allocates fiduciary responsibilities to other persons, the named fiduciary shall not be liable for any act or omission of those persons unless:

1. The appointment was imprudent or the named fiduciary fails to monitor the conduct and performance of the appointee; or
2. The named fiduciary breached his or her fiduciary responsibility under Section 405(a) of ERISA.

Plan Supervisor Is Not a Fiduciary. The Plan Supervisor is not a fiduciary under the Plan by virtue of processing and paying claims in accordance with the Plan’s rules as established and interpreted by the Plan Administrator.

A participant or beneficiary shall not rely on any oral statement from any employee or customer representative of the Plan Supervisor to:

1. Modify or otherwise amend the benefits, limitations and exclusions or other provisions of this Plan.
2. Increase, reduce, waive or void any coverage or benefits under this Plan.

Any statement by the Plan Supervisor should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a participant or beneficiary.
GENERAL INFORMATION

PLAN AMENDMENTS AND TERMINATION
The Plan Sponsor reserves the right to modify, amend or terminate the Plan completely or in part. The Plan may be amended or terminated by formal action of the board of directors of the Plan Sponsor or by appropriate action of any person(s) authorized to act on behalf of the board of directors of the Plan Sponsor.

If the Plan, or any benefit offered under the Plan, is amended, modified or terminated, the rights of covered persons are limited to covered charges incurred before the effective date of that amendment, modification or termination. Covered persons will be informed of any changes that affect their coverage.

ASSIGNMENTS
Benefits under the Plan may not be voluntarily or involuntarily assigned or alienated, provided, that payment of benefits of a covered person will be made directly to a physician, hospital or other provider furnishing services to the extent that the covered person has authorized such physician, hospital or other provider to receive direct payment of benefits due under the Plan. Assignment of benefits for any purpose other than direct payment to providers shall not be permitted and shall not be binding on the Plan, the Plan Administrator or the Employer.

CLERICAL ERROR & MISSTATEMENTS
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 any relevant information as to the amount of coverage shall have been misstated, the facts will determine whether or not, and how much, coverage is in force.

OVER PAYMENTS
If a member or any other person or entity receives a benefit payment that exceeds the amount of benefits payable under the Plan, the Plan has the right to either (i) require that the member or the person or entity that was paid return the amount of the overpayment or (ii) reduce any future benefit payments to the member or his/her dependents by the amount of the overpayment. This right does not affect any other right of recovery concerning the overpayment.

PLAN IS NOT AN EMPLOYMENT CONTRACT
The Plan is not a contract of employment, and participation in the Plan does not guarantee any person’s employment with the Employer.

PRIOR COVERAGE PROVISION
This provision applies only to a person who was covered on the date this Plan first became effective and who was covered under the prior plan, which this Plan replaced.

1. **Pre-existing Conditions.** Benefits for pre-existing conditions will be equal to the lesser of:
   a. benefits payable under the prior plan had it remained in effect; or
   b. benefits payable under this Plan.
   If any person is eligible for continuation of coverage under the prior plan, benefits under this Plan will be limited to only those eligible expenses not eligible for payment under continuation of coverage under the prior plan.

2. **Deductible.** This Plan will allow credit toward the deductible for any portion of the calendar year deductible that the covered person satisfied under the prior plan.
PRIVACY RIGHTS UNDER HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Plan protect the confidentiality of your private health information. A description of your privacy rights under HIPAA can be found in the Plan’s Notice of Privacy Practices provided upon enrollment.

Uses and Disclosures of Protected Health Information (PHI)
This Plan will not use or disclose your individually identifiable health information protected by HIPAA ("protected health information") except as necessary for treatment, payment, and other health care operations, or as permitted or required by law. The Plan also requires all of its business associates (as that term is defined by HIPAA) to observe HIPAA’s privacy requirements.

The Plan also may use or disclose protected health information about individuals covered under the Plan in communications with family members involved in the care or payment of health care of that individual, if relevant to such involvement. In addition, the Plan may disclose protected health information if required by law or for certain public health and national priority purposes, including: (1) as authorized and necessary to comply with workers’ compensation laws, (2) in response to a subpoena or other valid legal process, (3) to health oversight agencies and public health authorities, and (4) to authorized government officials for intelligence and national security activities authorized by law.

Disclosure Protected Health Information ("PHI") to Plan Sponsor
The Plan will disclose (or require the Plan Supervisor to disclose) PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Plan Sponsor will be subject to and consistent with the restrictions set forth below.

Restrictions on Plan Sponsor’s Use and Disclosure of (“PHI”)
1. The plan sponsor will neither use nor further disclose Member’s PHI, except as permitted or required by the Plan Documents, as amended or required by law.
2. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Member PHI agrees to the restrictions and conditions of the Plan, with respect to Member’s PHI.
3. The Plan sponsor will not use or disclose Member PHI for employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor.
4. The Plan Sponsor will report to the Plan any use or disclosure of Member PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
5. The Plan Sponsor will make PHI available to the Member who is the subject of the information in accordance with HIPAA.
6. The Plan Sponsor will make Member PHI available for amendment, and will on notice amend Member PHI, in accordance with HIPAA.
7. The Plan Sponsor will track disclosures it may make of Member PHI so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with HIPAA.
8. The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of Member PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.
9. The Plan Sponsor will, if feasible, return or destroy all Member PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor’s custody or
control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Member who is the subject of the PHI, when the Member’s PHI is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Plan Sponsor will limit the use or disclosure of any Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

10. The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.

11. The Plan Sponsor will ensure that any agent, including a subcontractor, to whom Plan Sponsor provides electronic PHI (that Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan), agrees to implement reasonable and appropriate security measures to protect this information.

12. The Plan Sponsor shall report any security incident of which it becomes aware to the Plan as provided below:
   a. In determining how and how often the Plan Sponsor shall report security incidents to the Plan, both Plan Sponsor and Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both Plan Sponsor and Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 CFR Part 164, Subpart C and that no further notice or report of such attempts will be required.
   b. Plan Sponsor shall, however, separately report to the Plan (i) any successful unauthorized access, use, disclosure, modification or destruction of the Plan’s electronic PHI of which Plan Sponsor becomes aware if such security incident either results in a breach of confidentiality, results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of the Plan’s electronic PHI, or results in a breach of availability of the Plan’s electronic PHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after Plan Sponsor becomes aware of the impact of such security incident upon the Plan’s electronic PHI.

13. Adequate separation between the Plan Sponsor and the Plan will be achieved by giving access to Member PHI to certain classes of employees under the control of the Plan Sponsor. Protected health information may be disclosed to and used by human resources, benefits, finance/accounting and information technology employees of the Employer who are responsible for carrying out administrative functions for the Plan – for example, benefit determinations, benefit payments, and claims audits. However, these employees will only have access to the information on a “need to know” basis and will use and disclose only the minimum necessary protected health information to accomplish the intended Plan administration purpose. Plan Sponsor has implemented procedures for handling non-compliance.
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