ST. MARTIN PARISH SCHOOL BOARD HEALTH BENEFIT PLAN BREAUX BRIDGE LA

Retirees Age 65 And Over Summary Plan Description

7670-04-412485

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BENEFITS ADMINISTERED BY

A UnitedHealthcare Company

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MEDICARE SUPPLEMENT HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan, as well as with information on Your rights and obligations under the ST. MARTIN PARISH SCHOOL BOARD HEALTH BENEFIT PLAN Medicare Supplement Retiree Health Plan (the "Plan"). You are a valued Retiree of ST. MARTIN PARISH SCHOOL BOARD HEALTH BENEFIT PLAN, and Your former employer is pleased to sponsor this Plan to provide benefits that can help meet Your health care needs by filling in some of the gaps in Medicare coverage. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions or if You have difficulty translating this document.

ST. MARTIN PARISH SCHOOL BOARD HEALTH BENEFIT PLAN is named the Plan administrator for this health Plan. The Plan administrator has retained the services of an independent Third Party Administrator to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims, and Southern Scripts for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, since they are solely claims-paying agents for the Plan administrator.

ST. MARTIN PARISH SCHOOL BOARD HEALTH BENEFIT PLAN assumes the sole responsibility for funding the benefits out of general assets; however, You help cover some of the costs of Covered Expenses through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan.

The Plan Administrator believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (also known as the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans (for example, the requirement for the provision of preventive health services without any cost sharing). However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act (for example the elimination of lifetime limits on benefits).

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status may be directed to the plan administrator at:

625 CORPORATE BLVD
BREAUX BRIDGE LA 70517
337-332-2105

You may also contact the U.S. Department of Health and Human Services at: www.cciio.cms.gov.

Some of the terms used in this document begin with capital letters, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

Each individual covered under this Plan will be receiving an identification card that he or she may present to providers whenever he or she receives health care services. On the back of this card are phone numbers to call in case of questions or problems.

This document contains information on the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan document. Therefore, it will be referred to as both the SPD and the Plan document. It is being furnished to You in accordance with ERISA.

This document became effective on July 1, 2016.

PLAN INFORMATION

Plan Name	ST. MARTIN PARISH SCHOOL BOARD HEALTH BENEFIT PLAN Medicare Supplement Health Benefit Plan
Name and Address Of Employer	ST. MARTIN PARISH SCHOOL BOARD HEALTH BENEFIT PLAN 625 CORPORATE BLVD BREAUX BRIDGE LA 70517
Name, Address, And Phone Number Of Plan Administrator	ST. MARTIN PARISH SCHOOL BOARD HEALTH BENEFIT PLAN 625 CORPORATE BLVD BREAUX BRIDGE LA 70517 337-332-2105
Named Fiduciary	ST. MARTIN PARISH SCHOOL BOARD HEALTH BENEFIT PLAN
Employer Identification Number Assigned By The IRS	72-6001274
Plan Number Assigned By The Plan	501
Type of Benefit Plan Provided	Self-funded Health and Welfare Plan providing group health benefits through a Medicare supplement plan.
Type Of Administration	The administration of the Plan is under the supervision of the Plan administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims. Southern Scripts provides administrative services related to pharmacy claims.
Name And Address Of Agent For Service Of Legal Process	ST. MARTIN PARISH SCHOOL BOARD HEALTH BENEFIT PLAN 625 CORPORATE BLVD BREAUX BRIDGE LA 70517 Service of legal process may also be made upon the Plan Administrator.
Funding Of The Plan	This Plan is funded by Retiree and employer contributions. Benefits are provided by a benefit Plan maintained on a self-insured basis by Your employer.

Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new enrollees, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
Plan's Fiscal Year	July 1 through June 30
Compliance	It is intended that this Plan comply with all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.
Discretionary Authority	The Plan administrator will perform its duties as the Plan administrator and, in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan administrator will be final and legally binding on all parties, except that the Plan administrator has delegated certain responsibilities to the Third Party Administrator(s) for this Plan. Any interpretation, determination, or other action of the Plan administrator or the Third Party Administrator(s) will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan administrator or the Third Party Administrator(s) will be based only on such evidence presented to or considered by the Plan administrator or the Third Party Administrator(s) at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan administrator or the Third Party Administrator(s) make, in their sole discretion, and, further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 004, 005, 006

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

	TRADITIONAL
Annual Deductible Per Calendar Year Excluding The Prescription Benefit Deductible: • Per Person • Per Family ***Note: If Medicare Covers The Service, The Plan Pays 100% Deductible Waived. If Medicare Does Not Cover The Service, The Plan Follows The Benefits Described In The SPD.***	 $625 $1,875
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan After Satisfaction Of Deductible	80%
Annual Total Out-Of-Pocket Maximum: Excluding The Prescription Benefit Out-Of-Pocket Maximum: • Per Person • Per Family	 $1,800 $5,400
Ambulance Transportation: • Paid By Plan After Deductible	80%
Durable Medical Equipment: • Paid By Plan After Deductible	80%
Emergency Services / Treatment: **Urgent Care:** • Co-pay Per Visit • Paid By Plan After Deductible **Emergency Room Only:** • Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours) • Paid By Plan After Deductible	 $25 100% $90 80%

	TRADITIONAL
Emergency Physicians Only: • Paid By Plan After Deductible	 80%
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility: • Co-pay Per Admission • Maximum Days Per Calendar Year • Paid By Plan After Deductible	 $100 Per Day Up To $300 120 Days 80%
Hearing Services: **Exams, Tests:** • Paid By Plan After Deductible **Hearing Aids:** To Age 18 • Maximum Benefit Every 3 Calendar Years • Paid By Plan After Deductible	 80% $1,400 Per Hearing Aid Per Ear 80%
Home Health Care Benefits: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours of Home Health Care Services.***	 40 Visits 80%
Hospice Care Benefits: **Hospice Services:** • Paid By Plan After Deductible **Bereavement Counseling:** • Paid By Plan After Deductible	 80% 80%
Hospital Services: **Pre-Admission Testing:** • Paid By Plan After Deductible **Inpatient Services Only:** • Co-pay Per Admission • Paid By Plan After Deductible **Inpatient Physician Charges Only:** • Paid By Plan After Deductible **Outpatient Services / Outpatient Physician Charges:** • Paid By Plan After Deductible **Outpatient Imaging Charges:** • Paid By Plan After Deductible	 100% $100 Per Day Up To $300 80% 80% 80% 80%

	TRADITIONAL
Outpatient Lab And X-Ray Charges: • Paid By Plan After Deductible **Outpatient Surgery / Surgeon Charges:** • Paid By Plan After Deductible	80% 80%
Manipulations: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	$600 80%
Mental Health Benefits: **Inpatient Services / Physician Charges:** • Maximum Days Per Calendar Year **Inpatient Services Only:** Included In Maximum • Co-pay Per Admission • Paid By Plan After Deductible **Inpatient Physician Charges Only:** Included In Maximum • Paid By Plan After Deductible **Residential Services Only:** • Maximum Days Per Calendar Year • Co-pay Per Admission • Paid By Plan After Deductible **Residential Physician Charges Only:** Included In Maximum • Paid By Plan After Deductible **Partial Hospitalization Services And Physician Charges:** • Maximum Days Per Calendar Year • Paid By Plan After Deductible **Outpatient Services And Physician Charges:** • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	 14 Days $100 Per Day Up To $300 80% 80% 50 Days $100 Per Day Up To $300 80% 80% 28 Days 80% 50 Visits 80%
Morbid Obesity Treatment: **Gastric Bypass Surgery (Includes All Related Complications):** • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	80% $25,000 80%

	TRADITIONAL
Laparoscopic Banding, Stomach Stapling And Gastric Sleeve (Includes All Related Complications): • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	 $10,000 80%
Diagnostic Services: • Paid By Plan After Deductible	 80%
Orthotic Appliances: • Paid By Plan After Deductible **Shoe Inserts-Custom Molded:** • Maximum Benefit Every 2 Calendar Years • Paid By Plan After Deductible	 80% 1 Pair 80%
Physician Office Visit: • Paid By Plan After Deductible	 80%
Physician Office Services: • Paid By Plan After Deductible	 80%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: **Preventive / Routine Physical Exams At Appropriate Ages:** • Paid By Plan **Immunizations:** • Paid By Plan **Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:** • Paid By Plan **Preventive / Routine Mammograms And Breast Exams:** • Maximum Exams Per Calendar Year • Paid By Plan ***Note: 3D Mammograms Are Not Covered.*** ***Note: First Mammogram Per Calendar Year Covered At Preventive / Routine Benefits Regardless Of Diagnosis.*** **Preventive / Routine Pelvic Exams And Pap Tests:** • Maximum Exams Per Calendar Year • Paid By Plan	 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 1 Exam 100% (Deductible Waived) 1 Exam 100% (Deductible Waived)

	TRADITIONAL
Preventive / Routine PSA Test And Prostate Exams: • Maximum Exams Per Calendar Year • Paid By Plan **Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:** • Paid By Plan	 1 Exam 100% (Deductible Waived) 100% (Deductible Waived)
Substance Use Disorder And Chemical Dependency Benefits: **Inpatient Services / Physician Charges:** • Maximum Days Per Calendar Year • Maximum Benefit Per Lifetime **Inpatient Services Only:** Included In Maximum • Co-pay Per Admission • Paid By Plan After Deductible **Inpatient Physician Charges Only:** Included In Maximum • Paid By Plan After Deductible **Partial Hospitalization Services And Physician Charges:** • Maximum Days Per Calendar Year • Paid By Plan After Deductible **Outpatient Services And Physician Charges:** • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	 14 Days 1 Confinement $100 Per Day Up To $300 80% 80% 28 Days 80% 50 Visits 80%
Supplemental Accident Expense Benefits - Including Dental Injuries: • Maximum Benefit Per Accident • Paid By Plan ***Note: Covered Expenses Must Be Incurred Within 90 Days From The Accident. Regular Plan Benefits Will Apply For Any Remaining Expenses.***	 $300 100% (Deductible Waived)
Temporomandibular Joint Disorder Benefits: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	 $300 80%

	TRADITIONAL
Therapy Services: **Occupational / Physical Outpatient Hospital And Office Therapy:** • Paid By Plan After Deductible **Speech Outpatient Hospital And Office Therapy:** • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	 80% 30 Visits 80%
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata: • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	 1 Wig (Cranial Prostheses), Toupee Or Hairpiece 80%
All Other Covered Expenses: • Paid By Plan After Deductible	 80%

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) 004, 005, 006	
Transplant Services At A Designated Transplant Facility: **Transplant Services:** • Paid By Plan	 80%
Transplant Services At A Non-Designated Transplant Facility: **Transplant Services:** • Paid By Plan After Deductible	 80%

NOTE: UMR (the claims administrator) does not administer the benefits within this provision. Please contact the Benefit Manager or Your employer with any questions related to this coverage.

PRESCRIPTION SCHEDULE OF BENEFITS **Benefit Plan(s) 004, 005, 006**	
Tier 1 – Southern Scripts Premium Choice Pharmacy Network • Covered Person's Co-pay Amount **Premium Choice Preferred Generic Drug** ***Note: Copayment Reduced For Premium Choice Generic Drugs At Restricted Quantities At Participating Premium Choice Pharmacy Providers Only.*** **Premium Choice Generic Drug** ***Note: Copayment Reduced For Premium Choice Generic Drugs At Participating Premium Choice Pharmacy Providers Only.*** Formulary Brand Drugs And Compounds Non-Formulary Brand Drugs	 $0 $10 $35 $50
Tier 2 – Southern Scripts National Pharmacy Network	
Annual Pharmacy Deductible Per Calendar Year ***Note: Excluding The Medical Benefit Deductible***: • Per Person • Per Family	 $100 $300
• Covered Person's Co-pay Amount Generic Drugs Formulary Brand Drugs And Compounds Non-Formulary Brand Drugs	 $15 (Deductible Waived) $40 $55

Note: You will pay the additional cost Your prescription Plan would incur if You elect to purchase a Brand Name Drug when a Generic Drug is available. If Your Qualified Practitioner certifies a Brand Name Drug is Medically Necessary when a Generic Drug is available, You will not pay the additional cost.

Note: Deductible is waived for covered vaccines.

Note: When the maximum amount shown in the Schedule of Benefits has been Incurred by A Covered Person of a family unit toward their calendar year Deductibles, the Deductibles of all Covered Persons of that family unit will be considered satisfied for that calendar year.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

MONTHLY PREMIUMS

In order to receive coverage under this Plan, Covered Persons must pay the required monthly premium. The Plan Administrator will regularly advise Covered Persons of the required level of premiums that must be paid.

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time the Covered Person receives certain services. Co-pays do not apply toward satisfaction of Deductibles, and they do not apply toward satisfaction of out-of-pocket maximums. The Co-pays and out-of-pocket maximums that the Covered Person must pay are shown in the Schedule of Benefits and Prescription Schedule of Benefits pages of this SPD.

DEDUCTIBLES

A Deductible is an amount of money paid once per Plan year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit.

Deductible amounts are shown on the Schedule of Benefits. The applicable Deductible must be met before any benefits will be paid under this Plan, unless indicated otherwise. A new Deductible must be met each Plan year.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

If You have family coverage, any combination of covered family members may help meet the maximum family Deductible, up to each person's individual Deductible amount.

PLAN PARTICIPATION

Plan Participation means that, after Medicare pays as primary:

- The Covered Person pays the Deductible.
- The Covered Person will also pay a portion of the Covered Expenses, as shown on the Schedule of Benefits, until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan pays in full after the out-of-pocket is met.

  Once the annual out-of-pocket maximum is reached, the Plan pays 100% of the Covered Expenses for the remainder of the Plan year.

  The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expenses, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts, as applicable.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as any Plan Participation will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). Pharmacy expenses the Covered Person incurs do not apply toward the out-of-pocket maximum of this Plan.

Once the Covered Person has met the out-of-pocket maximum for the year, the Plan will pay 100% of the remaining expenses.

The following will not be used to meet the out-of-pocket maximum:

- Co-pays.
- Expenses for services that are not covered by this Plan.
- Any charges above the limits specified in this SPD.
- Any amounts over the Usual and Customary amount, Negotiated Rate, or established fee schedule that this Plan pays.
- Annual Deductibles.
- Expenses paid by Medicare (generally), another health plan, or an insurance plan.

ELIGIBILITY AND ENROLLMENT

EMPLOYEE ELIGIBILITY (FORMER EMPLOYEES)

You are responsible for enrolling in the manner and form prescribed by Your former employer. Former employees are eligible for coverage under this Medicare Supplement Plan.

Retiree shall mean an Employee who was a covered Employee, as defined by the terms of this document, immediately prior to the date of retirement and who, upon retirement:

- Immediately received benefits from an approved state or state governmental agency defined benefit Plan, or
- Was not eligible for participation in such a Plan or had legally opted to not participate in such a Plan and;

  - Was employed prior to September 16, 1979, has ten years of continuous service with the employer and has reached the age of 65;
  - Was employed after September 16, 1979, has ten years of continuous service with Employer and has reached the age of 70; or
  - Was employed after July 8, 1992, has ten years of continuous service with employer, had a credit for at least forty quarters in the Social Security system at the time of employment and has reached the age of 65; or

- Immediately received retirement benefits from a state-approved or state governmental agency-approved defined contribution Plan and has accumulated the total number of years of creditable service, which would have entitled him / her to receive a retirement allowance from the defined benefit Plan of the retirement system for which the Employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution Plan shall be responsible for certification of eligibility hereunder the employer.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Retiree will not also be considered an eligible Dependent under this Plan.

DEPENDENT ELIGIBILITY

Eligibility Criteria: A Dependent is eligible for coverage under this Medicare Supplement Plan if, at the time of Your retirement, all of the following conditions are met:

- The Dependent was enrolled in ST. MARTIN PARISH SCHOOL BOARD HEALTH BENEFIT PLAN's active employee health plan on the day before Your employment ended, or You apply for coverage within 31 days of acquiring the Dependent due to marriage, birth, adoption, or Placement for Adoption or within 31 days after the Dependent loses other health coverage; or You apply for coverage during the annual open enrollment period; and
- The Dependent is eligible for Medicare due to age or disability; and
- The Dependent declined COBRA coverage that was offered to him or her when Your job ended, if applicable; and
- The former employee is covered under this Medicare Supplement Plan unless otherwise stated under the Termination section of this document.

An **eligible Dependent** includes each of the following people who meet the **eligibility criteria** stated above:

- Your legal spouse, provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator. Coverage under this Plan is available to the spouse of an eligible Employee if the spouse works full-time and is eligible for health coverage through his or her own employer. A surcharge will apply.

- Each Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following:

  - A natural biological Child;
  - A stepchild;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 18 as of the date of such placement;
  - A Child under Your (or Your Spouse's) Legal Guardianship as ordered by a court;
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);
  - A grandchild, as long as the Retiree's covered Dependent is the parent of the grandchild. Coverage for the grandchild will end when the Retiree's covered Dependent (the parent of the grandchild) is no longer eligible under this Plan or when the Dependent (the parent of the grandchild) reaches 26 years of age, whichever occurs first.

- A Dependent does not include the following:

  - A foster Child;
  - A Child of a Domestic Partner or a Child under Your Domestic Partner's Legal Guardianship;
  - A Domestic Partner;
  - A Dependent Child if the Child is covered as a Dependent of another Retiree at this company;
  - Any other relative or individual unless explicitly covered by this Plan.

A Child must meet all of the following conditions in order to be an eligible Dependent Child:

- A Dependent Child must be dependent upon the former employee for more than 50 percent of his or her support and maintenance, or must legally qualify to be claimed as a tax exemption on the Retiree's or spouse's federal income tax return. This financial requirement does not apply to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the retired employee's divorce or separation decree; and
- A Dependent Child must be unmarried; and

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday, and
- A Dependent Child may not re-enroll in the Plan under any circumstances; or
- If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would otherwise cease to be a Dependent under the terms of this Plan. The Plan may, for three years, ask for additional proof at any time, after which the Plan may ask for proof not more than once per year. Coverage may continue subject to the following minimum requirements:

  - The Dependent must not be able to hold a self-sustaining job due to the disability; and
  - Proof of the disability must be submitted as required (Notice of Social Security income is acceptable); and
  - The Retiree must still be covered under this Plan.

  A Dependent Child age 26 and over who is no longer on the Plan and becomes Totally Disabled will not be allowed to re-enroll under the extended coverage for Dependents.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to attend school as a Full-Time Student for reasons other than Illness or Injury, or the Dependent does not meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent or Retiree for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

EFFECTIVE DATE OF COVERAGE

- Your coverage will become effective under this Plan the day after Your coverage under the active employee plan ends, if You apply for coverage within 31 calendar days following termination of employment.
- The eligible Dependent's coverage will become effective on the later of the following dates:

  - The date Your coverage under this Plan begins if the Dependent was covered under the active employee plan on the day before You retired; or
  - The date set forth under the Special Enrollment Provision if Your Dependent is eligible to enroll under the Special Enrollment Provision and application is made within 31 days following the event; or
  - The date specified in a Qualified Medical Child Support Order or the date the Plan administrator determines that the order is a QMCSO; or
  - July 1 following application during the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

Note: Retirees (and their Dependents) who decline coverage under this Plan when it is initially offered are not eligible for special enrollment due to loss of other coverage. Similarly, Retirees who are not Covered Persons will not be eligible to enroll upon acquisition of new Dependents.

LOSS OF HEALTH COVERAGE

If Your eligible Dependents lose other health coverage, are otherwise eligible for coverage under this Plan, and did not enroll when first eligible because they had other health coverage, they may enroll for health coverage under this Plan if the following conditions are met:

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

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

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

You or Your Dependent must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended.

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

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

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

CHANGE IN FAMILY STATUS

If a person becomes an eligible Dependent through marriage, birth, adoption, or Placement for Adoption, the newly acquired Dependent who is not already enrolled may enroll for health coverage under this Plan during a special enrollment period. The Retiree must apply for coverage within 31 days of the marriage, birth, adoption, or Placement for Adoption.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

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

- In the case of marriage, on the date of the marriage; or

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

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

- In the case of loss of coverage, on the date following loss of coverage.

TERMINATION

For information about continuing coverage, refer to the COBRA Continuation of Coverage section of this SPD.

A person's coverage under this Plan will end on the earliest of:

- The date this Plan is terminated; or
- The date coverage for the former employee's benefit class is terminated; or
- The date You cancel coverage or fail to pay premiums as required. Coverage may be dropped at any time. If You choose to discontinue coverage, You permanently give up Your right to future coverage under this Plan for You and Your Dependents; or
- The date You or Your Dependent submits a false claim or commit any fraudulent act related to this Plan or any other group plan; or
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or
- The last day of the month in which Your Dependent no longer qualifies as a Domestic Partner; or
- The date Dependent coverage is no longer offered under this Plan; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section, unless the Child qualifies for extended Dependent coverage; or
- If Your Dependent Child qualifies for extended Dependent coverage as Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or
- The last day of the month the former employee dies.

SURVIVOR HEALTH CARE

The Plan provides an option for all surviving spouses of deceased Retirees covered by the Plan by virtue of their family relationship to a group member to continue as a member of the Plan when their eligibility for group coverage ceases due to death of the Retiree.

The continuation option provided above shall not be conditioned upon any physical examination.

The continuation option shall entitle the surviving spouse to coverage identical in scope to that provided for under the Plan.

The policyholder shall be responsible for billing and collection of the premium; however, the premium amount shall not exceed the premium assessed for each group member under the group Plan. The premium shall be based upon the community costs of the pool of members of the group Plan, family members or Dependents covered under the group Plan.

The surviving spouse shall have ninety (90) days after the date of death to notify the Plan Administrator that the continuation option will be exercised. Coverage under the Plan shall not be terminated during the ninety (90) day notification period. No Waiting Period shall be required.

If the continuation option is exercised, coverage of the surviving spouse under the Plan shall continue without interruption and may not be terminated, unless one of the following occurs:

- The surviving spouse fails to make timely payment of the required premium amount.
- The surviving spouse becomes eligible to participate in another group.
- The surviving spouse remarries.
- The date coverage under the Plan ends for all persons covered by the Plan.

If the Plan has been furnished with the home address of the surviving spouse and has been notified of the death of the Retiree, the Plan shall notify the surviving spouse of the right to the continuation option. This coverage shall not diminish any protection already provided pursuant to collective bargaining agreements and employer sponsored plan that are more favorable to the surviving spouse.

Survivor Health Care Change of Classification

- **Adding or Deleting Dependents.** Notice must be furnished to the program by the plan member whenever a Dependent is added to or deleted from the Plan member's coverage, regardless of whether or not such addition or deletion would result in a change in class of coverage. Such notice must be provided within thirty (30) days of the addition or deletion of the Dependent.
- ☐**Change in Coverage.** When, by reason of a change in family status (i.e., marriage, birth of Child), the class of coverage is subject to change, such change shall take effect on the date of the change, provided an application form is submitted within thirty-one (31) days of the date of the change.
- **Notification of Change of Error.** It is the responsibility of the Retiree to notify the program of any change or error in classification of coverage. Any determined shall be corrected on the first of the following month. All refunds of contributions shall be limited to two (2) months from the date notice is received by the program.

COBRA CONTINUATION OF COVERAGE
Retiree Health Care Plan

Important: Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your covered Dependents, and what You and Your Dependents need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally does not accept Late Enrollees.

The COBRA Administrator for this Plan is: UMR

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they may otherwise lose coverage. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event (outlined below). When a Qualifying Event causes (or will cause) a Loss of Coverage, the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage, even if You or Your Dependent is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of this COBRA election.

DEFINITIONS

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before a Qualifying Event. Loss of Coverage includes a change in coverage terms, a change in plans, termination of coverage, a partial Loss of Coverage, an increase in Retiree cost, and other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after a Qualifying Event, but must always occur within the applicable 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA rights.

Qualified Beneficiary means a person covered by this Medicare Supplement Plan immediately before a Qualifying Event. A Qualified Beneficiary may be a former employee, the legal spouse of a former employee, or the Dependent Child of a former employee. The retired employee is a Qualified Beneficiary if coverage is lost due to bankruptcy of the employer. A Dependent Child also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered retired employee.
- Divorce or legal separation of the covered retired employee from the retired employee's spouse. (Also, if a retired employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation, and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)
- A Dependent Child no longer qualifies as a Dependent as defined by the Plan.
- Employer bankruptcy. Filing a proceeding in bankruptcy under title 11 of the United States Code may be a Qualifying Event. If a proceeding is filed with respect to this employer, and that bankruptcy results in the Loss of Coverage of any retired employee covered under this Plan, then the retired employee is a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse or surviving spouse and Dependent Children will also be Qualified Beneficiaries if bankruptcy results in their Loss of Coverage under this Plan.

Note: A spouse or a Dependent Child newly acquired through birth or adoption during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provisions of the Plan apply to enrollees during continuation coverage. A Dependent other than a newborn or newly adopted Child who is acquired and enrolled after the original Qualifying Event is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

In order to be eligible to receive COBRA continuation coverage, covered former employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the former employee and spouse, or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, whether to Your former employer or to the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information (a form for notifying the COBRA Administrator is available upon request):

- The Qualified Beneficiary's name, current address, and complete phone number;
- The group number and the name of the former employer,
- A description of the Qualifying Event (i.e., the life event experienced), and
- The date the Qualifying Event occurred or will occur.

Send all notices or other information required by this Summary Plan Description in writing to:

UMR
COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206
Phone Number: (800) 207-1824

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes to the addresses of family members. Keep copies of all notices You send to the Plan Administrator or to the COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER'S OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The former employer will give notice to the COBRA Administrator when coverage terminates due to the death of the former employee, the former employee becoming eligible for Medicare benefits due to age or disability (Part A, Part B, or both) or termination of coverage due to the former employer's bankruptcy. The former employer will notify the COBRA Administrator within 30 calendar days of when one of these events occurs.

QUALIFIED BENEFICIARY'S OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of divorce or legal separation of the former employee and a spouse or a Dependent Child ceasing to be eligible for coverage under the Plan. The covered former employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar-day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of the Qualifying Event from the former employer, the covered former employee, or the Qualified Beneficiary.

IMPORTANT: The group health plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the Qualified Beneficiary fails to provide this notice to the Plan Administrator within the allowable time periods stated above.

APPLYING FOR CONTINUATION COVERAGE UNDER COBRA

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that should be completed in order to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 days after the later of:

- The date Your Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an Election Notice.

A Qualified Beneficiary must notify the COBRA Administrator of his or her election in writing in order to continue group health coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, the Qualified Beneficiary's group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, coverage under this Plan will be reinstated retroactively to the date coverage was lost, provided the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the COBRA election material and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will become effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the former employer and former employee contributions. This cost may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once per year.

The **initial payment** is due no later than 45 days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage. However, the Qualified Beneficiary will receive specific payment information, including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow him or her 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, then the occurrence will be treated as non-payment and the Qualified Beneficiary(ies) will lose coverage under the Plan in accordance with the Plan language above.

NOTE: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S OBLIGATIONS WHILE ON COBRA CONTINUATION

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, written notice to the COBRA Administrator is required within 30 calendar days of the date any of one the following events occur:

- The Qualified Beneficiary's marital status changes. Refer to the Special Enrollment Provision section of this Plan for additional information regarding special enrollment rights.

- A Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A final determination is made by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- Any Qualified Beneficiary becomes covered by another group health plan or enrolls in Medicare Part A or Part B.

Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

The maximum amount of time that covered Dependents may have COBRA continuation coverage is 36 months if coverage is lost due to the retired employee's death, due to divorce or legal separation, or due to a Dependent Child's loss of eligibility as a Dependent as defined in this document.

If, however, bankruptcy of the former employer is the Qualifying Event that causes Loss of Coverage, Qualified Beneficiaries may elect COBRA coverage for the following maximum period:

- The covered retired employee may continue COBRA coverage for the rest of his or her life.
- COBRA coverage for a covered spouse or surviving spouse or for a Dependent Child of the retired covered employee ends on the earlier of (1) the date the Qualified Beneficiary dies; or (2) the date that is 36 months after the death of the retired covered employee.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

EARLY TERMINATION OF COBRA CONTINUATION

Continuation coverage under COBRA may terminate before the end of the above maximum coverage periods for any of the following reasons:

- This former employer ceases to maintain a group health plan for any employees. (Note that if the former employer terminates the group health plan under which You are covered, but still maintains another group health plan for other, similarly situated employees, You will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same.)

- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing conditions for the beneficiary.

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE

At the time of a COBRA Qualifying Event, a Qualified Beneficiary has two primary options. The first is to waive his or her right to COBRA and make an election for coverage, whether group health coverage or insurance coverage through the individual market or the exchanges, in accordance with his or her HIPAA special enrollment rights. Please refer to the Special Enrollment Provision section for further details. The second option is to elect COBRA continuation coverage. If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary since it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

The Plan Administrator:
ST. MARTIN PARISH SCHOOL BOARD HEALTH BENEFIT PLAN
625 CORPORATE BLVD
BREAUX BRIDGE LA 70517

The COBRA Administrator:
UMR COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206

PROVIDER NETWORK

This coverage provides for the use of a provider organization. Benefits are paid at the same level regardless of which provider is chose, but First Health Shared Savings providers have agreed to provide certain discounts on covered services, reducing the Covered Person's out-of-pocket expenses.

The Plan does not limit a Covered Person's right to choose his or her own medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan or is subject to a limitation or exclusion.

To obtain more information on First Health Shared Savings providers, call the number on the back of the Plan's identification card.

- **The Program for Transplant Services at Designated Transplant Facilities is:**

  OptumHealth

Provider Directory Information

Each covered Employee, COBRA participant, and Child or guardian of a Child who is considered an alternate recipient under a Qualified Medical Child Support Order will automatically be given or electronically provided a separate document, at no cost, that lists the participating network providers for this Plan. The Employee should share this document with other covered individuals in his or her household. If a covered spouse or Dependent wants a separate provider list, he or she may make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

TRANSITIONAL CARE

Certain eligible expenses that would have been considered at the In-Network benefit level by the prior claims administrator, but that are not considered at the In-Network benefit level by the current claims administrator, may be paid at the applicable In-Network benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous PPO but who is not a member of the Plan's current PPO in the Employee's or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the In-Network medical plan benefit level may continue for 90 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplants for patients under active treatment (e.g., seeing a Physician on a regular basis, being on a transplant waiting list, or being ready at any time for a transplant).
- Being an Inpatient in a Hospital on the Covered Person's Effective Date.
- Post-acute Injury or surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral health (any previous treatment).

You or Your Dependent must call UMR within 30 days prior to Your Effective Date or within 30 days after Your Effective Date to see if You or Your Dependent is eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, treatment for minor Illnesses, and elective surgical procedures will not be covered by transitional level benefits.

COVERED MEDICAL BENEFITS
(Additional Details)

This Plan covers a portion of the same Medically Necessary benefits that Medicare covers, subject to any limitations of Medicare. The Plan also provides other benefits for Covered Persons. Please refer to the Schedule of Benefits in this SPD for what this Plan covers, and to Your Medicare booklets for information on what Medicare covers.

1. **Abortions:** If a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term or if the pregnancy was the result of incest or rape.

2. **Allergy Treatment**, including injections, testing, and serum.

3. **Ambulance Transportation**: Medically Necessary ground Ambulance Transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the closest facility in case of Emergencies. An air ambulance is covered only in an Emergency situation where serious danger to Your life or health could occur if You were transported by ground ambulance. Transportation from a Hospital or Skilled Nursing Facility to another location is generally not covered unless transportation in any other vehicle would endanger Your health. All ambulance suppliers must accept Medicare Assignment.

4. **Anesthetics and Their Administration** while You are in an Inpatient Hospital or being treated on an Outpatient basis.

5. **Augmentation Communication Devices** and related instruction or therapy.

6. **Autism Spectrum Disorders (ASD) Treatment,** when Medical Necessity is met.

   (ASD includes Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, Rett Syndrome, and Pervasive Developmental Disorders.)

   ASD treatment may include any of the following services: diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy.

   Treatment is prescribed and provided by a licensed health care professional practicing within the scope of his or her license (if ABA therapy, preferably a Board Certified Behavior Analyst, or BCBA).

   If ABA therapy meets Medical Necessity, frequency and duration will be subject to current UMR guidelines (for example, ABA treatment up to 25 hours per week for 3-6 months). Treatment plans specific to ABA therapy with goals-progress and updates are required at least every 6 months for review of ongoing therapy to evaluate continued Medical Necessity.

   Treatment is subject to all other Plan provisions as applicable (such as Prescription benefit coverage, behavioral/mental health coverage, and/or coverage of therapy services).

   Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Experimental, Investigational, or Unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through a school district).

7. **Blood** that You receive on an Inpatient or Outpatient basis.

8. **Braces** for arms, legs, back, or neck.

9. **Breast Prostheses** (including surgical brassieres) after mastectomies.

10. **Breast Reductions** if Medically Necessary.

11. **Cardiac Rehabilitation** programs if referred by a Physician, for patients who have certain cardiac conditions, including, but not limited to, the following:

    - The Covered Person had a heart attack in the last 12 months; or
    - The Covered Person had coronary bypass surgery; or
    - The Covered Person had a stable angina pectoris.

    Covered services include:

    - Phase I cardiac rehabilitation, while the Covered Person is an Inpatient.
    - Phase II cardiac rehabilitation, while the Covered Person is in a Physician-supervised Outpatient monitored, low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure, and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

12. **Cataract or Aphakia Surgery.** Also see eyeglasses.

13. **Chemotherapy.**

14. **Dental Conditions**: A serious dental condition requiring Inpatient treatment or Outpatient treatment in a Hospital, a surgical day care unit, or a participating ambulatory surgical center for: surgical removal of unerupted teeth or impactions in the bone; extraction of seven or more permanent teeth at one time; reduction of a fracture; gingivectomies involving two or more gum quadrants; and excision of a tumor (except that a radicular cyst must involve the roots of three or more teeth). When these procedures can be performed safely in a dentist's office, they are not covered under this Plan.

15. **Diabetes Supplies and Services**: Blood glucose test strips, blood glucose meters, lancet devices and lancets, glucose control solutions for checking the accuracy of test strips and monitors, and diabetes self-management training from Medicare-approved programs. Other diabetic services as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare are also covered.

16. **Diabetes Treatment**: Charges Incurred for the treatment of diabetes and diabetic self-management education programs and nutritional counseling by a registered dietician.

17. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. Coverage also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same as for any other Illness.

18. **Durable Medical Equipment** if prescribed by a Physician for use in Your home. Durable Medical Equipment (DME) must be durable, must be used for medical reasons, and must not usually be useful to someone who is not sick or injured. DME items may be obtained only from a supplier who accepts Medicare Assignment. The amount that You pay may vary. Medicare requires that some equipment be rented, and that other equipment be purchased. The type of Durable Medical Equipment that Medicare may cover includes, but is not limited to: Air fluidized beds, blood glucose monitors, commode chairs, crutches, home oxygen equipment and supplies, Hospital beds, infusion pumps, nebulizers, patient lifts to lift patients from beds or wheelchairs, suction pumps, traction equipment, walkers, and wheelchairs.

19. **Emergency Room Hospital and Physician Services** when Your health is in serious danger. (Emergency services are generally not covered in foreign countries.)

20. **Emergency Services Provided in a Foreign Country,** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital or Physician services in a provider's office, as shown in the Schedule of Benefits.

21. **Eyeglasses**: Following cataract surgery with an intraocular lens, the Plan will help pay for cataract glasses, contact lenses, or intraocular lenses provided by an optometrist, as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare. Only standard frames are covered.

22. **Foot Care**: Medically Necessary treatment of Injuries or diseases of the foot, including:

    - Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet, when surgery is performed.
    - Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
    - Treatment of bunions when an open cutting operation or arthroscopy is performed.

23. **Hearing Services** include:

    - Exams, tests, services, and supplies to diagnose and treat a medical condition.
    - Purchase or fitting of hearing aids.

24. **Home Health Care Services**: Intermittent skilled nursing care, physical therapy, speech language pathology services, or occupational therapy services that You receive in Your home for the treatment of an Illness or Injury. You must be considered homebound as defined by Medicare. The home health agency must be approved by the Medicare program.

25. **Hospice Care Services**: Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and may include:

    - **Assessment,** which includes an assessment of the medical and social needs of the Terminally Ill person and a description of the care required to meet those needs.
    - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time Home Health Care services.

- **Outpatient Care,** which provides or arranges for other services related to the Terminal Illness, including the services of a Physician or Qualified physical or occupational therapist, or nutrition counseling services provided by or under the supervision of a Qualified dietician.
- **Bereavement Counseling** services that are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and the charges for which are bundled with other hospice charges. Counseling services must be provided by a licensed social worker, licensed pastoral counselor, psychologist, or psychiatrist. The services must be furnished within six months of death.

The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. However, services are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician.

26. **Hospital Services (Including Inpatient Services and Ambulatory Surgery Centers). The following services are covered:**

    - Semi-private room and board.
    - Intensive care unit room and board.
    - Miscellaneous and ancillary services.
    - Blood, blood plasma, and plasma expanders, when not available without charge.

27. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

28. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition of, alleviates the symptoms of, slows the harm to, or maintains the current health status of the Covered Person.

    Infertility Treatment does not include Genetic Testing. (See General Exclusions for details).

29. **Kidney Dialysis** as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

30. **Laboratory or Pathology Services**, including laboratory or pathology tests and interpretation charges for covered benefits.

31. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

32. **Massage Therapy.** (See Therapy Services below.)

33. **Macular Degeneration** treatment for people with age-related macular degeneration. The treatment is referred to as ocular photodynamic therapy with verteporfin.

34. **Mental Health Treatment** needed on an Inpatient or Outpatient basis to help diagnose and treat mental health conditions, as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

35. **Morbid Obesity Treatment** includes only the following treatments if those treatments are determined to be Medically Necessary and be appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.

- Bariatric surgery, including, but not limited to:
  - Gastric or intestinal bypasses (Roux-en-Y, biliopancreatic bypass, and biliopancreatic diversion with duodenal switch).
  - Stomach stapling (vertical banded gastroplasty, gastric banding, and gastric stapling).
  - Lap band (laparoscopic adjustable gastric banding).
  - Gastric sleeve procedure (laparoscopic vertical gastrectomy and laparoscopic sleeve gastrectomy).
- Charges for diagnostic services.

This Plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions section of this SPD.

36. **Nutritional Supplements, Vitamins, and Electrolytes** when the sole source of nutrition. These items must be prescribed by a Physician and administered through enteral feedings. Coverage includes supplies related to enteral feedings.

37. **Nutritional Therapy Services** for people with diabetes or kidney disease (if not on dialysis), and after a kidney transplant when referred by a Physician. Nutritional assessment, therapy, and counseling may be provided by a registered dietician or Medicare-approved nutrition professional.

38. **Oral Surgery** includes:

- Excision of partially or completely impacted teeth.
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological examinations.
- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
- Reduction of fractures and dislocations of the jaw.
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands, or ducts.
- Excision of exostosis of jaws and hard palate.

39. **Oxygen Therapy.** The Plan covers rental of oxygen equipment, or, if You own Your own equipment, the Plan will help pay for oxygen contents and supplies for the delivery of oxygen if approved by Medicare. Portable oxygen is not covered when provided only as a backup to a stationary oxygen system.

40. **Physician Office Visits** for Medically Necessary services and covered preventive medical care.

41. **Pre-Admission Testing,** if necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

42. **Prescription Drugs** if approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

43. **Prescription Medications** that are administered or dispensed as take-home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility, or Skilled Nursing Facility) and that require a Physician's Prescription. Coverage does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

44. **Prosthetic Devices** needed to replace a body part or function, and as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

45. **Radiation Therapy.**

46. **Reconstructive Surgery** includes:

    - Surgery following a mastectomy under the Women's Health and Cancer Rights Act (WHCRA). Under the WHCRA, the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments that include all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
    - Surgery to restore a bodily function that has been impaired by a congenital Illness or anomaly, by an Accident, or from an infection or other disease of the involved part.

47. **Routine Care (Preventive Care)** as listed on the Schedule of Benefits, if applicable, including:

    - Colorectal cancer screening.
    - Bone mass measurements.
    - Glaucoma screening.
    - Mammogram screening.
    - Pap test and pelvic examination.
    - Prostate cancer screening.
    - Vaccinations.

48. **Second Surgical Opinion** if given by a board-certified specialist in the medical field related to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

49. **Skilled Nursing Facility Care.** The Plan will pay for care when You are transferred to a Skilled Nursing Facility from a Hospital if:

    - You were hospitalized for 3 or more consecutive days, not including the day You leave the Hospital; and
    - You enter the Skilled Nursing Facility within 30 days after leaving the Hospital for the same or related reason that resulted in Your Hospital confinement, as required by Medicare; and
    - Your doctor has stated that You need daily skilled care and that it must be provided by skilled nursing or rehabilitation staff.

50. **Sleep Disorders** if Medically Necessary.

51. **Sleep Studies.**

52. **Substance Use Disorder Services** to the extent approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

53. **Supplemental Accident Expenses Benefit** as shown on the Schedule of Benefits.

54. **Surgery and Assistant Surgeon Services** if determined to be Medically Necessary by the Plan. For multiple or bilateral procedures during the same operative session, it is customary for health care providers to reduce their fees for any secondary procedures. Unless there is a network contract, the industry guidelines are to allow the full Usual and Customary fee allowance for the primary procedure, and 50% of the Usual and Customary fee allowance for all secondary procedures. These allowable amounts are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

55. **Temporomandibular Joint Disorder (TMJ) Services** include:

    - Diagnostic services.
    - Surgical treatment.
    - Non-surgical treatment (including intraoral devices or any other non-surgical method to alter occlusion and/or vertical dimension).

    Coverage does not include orthodontic services.

56. **Therapy Services**: Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

    - **Occupational therapy** by a Qualified occupational therapist.
    - **Physical therapy** by a Qualified physical therapist.
    - **Respiratory therapy** by a Qualified respiratory therapist.
    - **Massage therapy** by a Qualified chiropractor or a Qualified physical therapist (PT).
    - **Speech therapy** by a Qualified speech therapist.

57. **Transplant Services.** (Refer to Transplant section of this SPD.)

58. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

59. **Wigs (Cranial Prostheses), Toupees, and Hairpieces** for hair loss due to cancer treatment or alopecia related to a medical condition.

60. **X-Rays:** Medically Necessary diagnostic X-rays that are ordered by Your treating Physician.

TRANSPLANT BENEFITS

Refer to the Care Management section of this SPD for prior authorization requirements

This coverage provides You with a choice for transplant care. The Plan provides incentives to You and Your covered Dependents by giving You the option of using a Designated Transplant Facility. While the Plan does not require You to use a Designated Transplant Facility in order to receive benefits You may receive better benefits if You do so. A Designated Transplant Facility is a facility that must meet extensive criteria in the areas of patient outcomes that include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

DEFINITIONS

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

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician's charges, organ and tissue procurement, tissue typing, and Ancillary Services.

Designated Transplant Facility means a facility that has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Non-Designated Transplant Facility means a facility that does not have an agreement with the transplant provider network with whom the Plan has a contract. This may include a facility that is listed as a participating provider.

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation, and the storage of human organ and tissue that is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated or Non-Designated Transplant Facility due to an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge or the Plan’s Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant-related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be an individual Plan exclusion.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated or Non-Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including a bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. Coverage includes the cost of donor testing, blood typing, and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor-related complications during the transplant period, per the transplant contract, if the recipient is a Covered Person under this Plan.

The Plan will provide donor services at a Non-Designated Transplant Facility for initial acquisition/procurement only, up to the maximum listed on the Schedule of Benefits, if any. Complications, side effects, or injuries are not covered unless the donor is a Covered Person.

Benefits are payable for the following transplant types:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by care management.
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous) for certain conditions.
- Small bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by transplant facility, the Plan will allow him or her to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant-related services or supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.

- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells, or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.

- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.

- Transplants considered Experimental, Investigational, or Unproven.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell), or allogeneic transplant (bone marrow or peripheral stem cell) for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION DRUG BENEFITS

Administered by Southern Scripts

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact the benefit manager or Your Employer with any questions related to this coverage or service.

Pharmacy Drug Charge

Participating Pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Southern Scripts is the administrator of the Pharmacy Drug Plan (PBM). Contact info: www.southernscripts.net: 800-710-9341.

Copayments

The Co-payment is applied to each covered Pharmacy Drug or Mail Order Drug charge and is shown in the Schedule of Benefits. The Co-payment amount is not a covered charge under the medical Plan. Any one Pharmacy Prescription is limited to a 30-day supply. Any one Mail Order Prescription is limited to a 90-day supply.

If a drug is purchased from a non-Participating Pharmacy, or a Participating Pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the Schedule of Benefits will be the ingredient cost and dispensing fee.

Prescription Drugs purchased from a non-Participating Pharmacy, or a Participating Pharmacy when the Covered Person's ID card is not used are not covered.

*For any manufacturer-subsidized drug that is otherwise covered under the Plan, the Plan reserves the right to apply a different Co-payment in order to utilize a subsidy / coupon value for the drug.

Mail Order Drug Benefit Option

The Mail Order Drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

Dispensing Limits:

Retail Pharmacy Providers: 30 Day Supply.
Mail Order Provider: 90 Day Supply.
Specialty Drug Provider: 30 Day Supply.

Dispense as Written

A Physician dispense as written Prescription will cost the Covered Person the Brand Name Co-payment. Physicians who insist upon the use of a Brand Name Drug for a multisource drug must indicate Brand Medically Necessary on the face of the Prescription. If a Physician authorizes the use of a Generic Drug for a Brand Name Drug, but the Covered Person insists on the use of a Brand Name Drug, then the Covered Person must pay the difference in price.

Premium Choice Generic Program

Premium Choice Generic Program provides for up to a 30-day supply of eligible Generic medications at a reduced Co-pay. To participate in the Premium Choice Generic Program, Generic medications must be for common dosages and / or quantities and must be filled at a participating Premium Choice Pharmacy Provider. A list of Generic Drugs covered under the program may be obtained at: www.southernscripts.net, and may change at any given time. Plan Sponsor may modify or discontinue the program at any time without notice. Generic Drugs covered and / or pricing under the Premium Choice Generic Program may vary and / or are subject to the following:

- Specific Pharmacy Provider.
- State in which the Prescription is filled.
- Specific dosage formulations – not all formulations are covered for a specific drug.
- Compounded products are excluded.
- Dosage/quantity restrictions may apply.
- Limited to specific manufacturers and subject to adequate supplies being available.
- Program details are subject to change without advance notice.

Covered Prescription Drugs

- All drugs prescribed by a Physician that require a Prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.

- All compounded Prescriptions containing at least one Prescription ingredient in a therapeutic quantity. Compounded Prescriptions are not covered if:

  - Similar to a commercially available product; and / or
  - Active ingredient(s) are being used for a non-FDA approved indication; and / or
  - Active ingredients are that of drugs withdrawn or removed from the market due to safety concerns.

- Insulin and other diabetic supplies when prescribed by a Physician. Other injectables are not covered unless otherwise noted.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one Prescription will be limited to:

- Refills only up to the number of times specified by a Physician.
- Refills up to one year from the date of order by a Physician.

Expenses Not Covered

Any of the limitations and exclusions listed may be deleted or revised as shown in the Schedule of Benefits. Unless otherwise shown as covered in the Schedule of Benefits, the following are not covered, regardless of claim of Medical Necessity.

This benefit will not cover a charge for any of the following:

- **Administration.** Any charge for the administration of a covered Prescription Drug, unless otherwise specified. Prescription Drugs not approved for self-administration are excluded. Oral or self-injectable drugs are excluded when obtained from a Physician or other provider unless the provider is contracted through the Pharmacy Benefit Manager (PBM).

- **Allowable charge.** Any charge(s) exceeding the allowable charge.

- **Appetite suppressants.** A charge for appetite suppressants, weight loss medications, or other anti-obesity therapies.

- **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed in covered under the medical benefit (unless provide in conjunction with the Specialty Pharmacy Program and not otherwise excluded).

- **Contraceptives.** Devices, implants, or injectable dosage forms.

- **Devices.** Devices of any type, even though such devices may require a Prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

- **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

- **Drug Utilization Programs.** Any drug subject to utilization management program such as step therapy or Prior Authorization when the drug was not utilized/approved according to program specifications.

- **Experimental.** Experimental drugs and medicines or any medication not proven effective, even though a charge is made to the Covered Person.

- **FDA.** Any drug not approved by the Food and Drug Administration, unless otherwise listed.

- **Growth hormones.** Growth hormones are absolutely excluded from coverage and/or charges for any other drugs to enhance physical growth or athletic performance or appearance.

- **Immunization.** Immunization agents or biological sera other than influenza, pneumonia and herpes zoster vaccinations.

- **Impotence.** A charge for impotence medication, aids, or devices.

- **Infertility.** A charge for infertility medication.

- **Injectable.** A charge for hypodermic syringes and / or needles, injectables or any Prescription directing administration by injection (other than for insulin, anticoagulants, anaphylaxis, glucagon, and those products included in the Specialty Pharmacy Program).

- **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while hospitalized, incarcerated or otherwise confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

- **Investigational.** A drug or medicine labeled: "Caution – limited by federal law to investigational use".

- **Medication exclusions.** A charge excluded under medical General Exclusions, including but not limited to abortifacients, contraceptives devices and cosmetics.

- **No charge.** A charge for Prescription Drugs, which may be properly received without charge under local, state or federal programs.

- **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

- **No Prescription.** A drug or medicine that can legally be bought without a written Prescription. This does not apply to injectable insulin or diabetic testing supplies.

- **Refills.** Any refill that is requested more than one year after the Prescription was written or any refill that is more than the number of refills ordered by the Physician. Any refill required prior to seventy-five percent (75%) of day supply being used.

- **Replacement.** Any charge related to the replacement of lost or stolen drugs, or those drugs mishandled or damaged.

- **Self-administration.** Prescription drugs approved for self-administration. Oral or self-injectable drugs are excluded when obtained from a Physician or other provider unless the provider is contracted through PBM.

- **Smoking Cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent products, for smoking cessation.

- **Supplements.** Any dietary, herbal, vitamin, and/or mineral supplements used for general nutrition, including "Medical Foods" except for prenatal vitamins required a Prescription or Prescription vitamin supplements containing fluoride.

HEARING AID BENEFITS

This Plan includes a benefit that allows Covered Persons to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by EPIC Hearing Healthcare.

This benefit may be accessed under the Plan by calling EPIC at its toll-free number: 1-866-956-5400. Once contacted, one of EPIC's hearing professionals will coordinate the Covered Person's care and direct him or her to the nearest appropriate provider.

The hearing aid benefit being provided through EPIC consists of discounted hearing aids and related testing and fitting. EPIC discounts may be as much as 50% below manufacturer's suggested retail prices and up to 35% lower than most discount offers. EPIC will require that the Covered Person pay for his or her hearing aids and other services not covered under the Plan out-of-pocket prior to the delivery of services.

In the event that You have questions or complaints about the hearing aid products or services offered under the Plan, contact EPIC directly at its toll-free number or write to: EPIC Hearing Services, 3191 W. Temple Ave. Ste. 200, Pomona, CA 91768.

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. (Coverage does not include services provided in a community based residential facility or group home.)

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered, subject to all of the following:

- The Covered Person must receive the services in person at a therapeutic medical facility; and
- The services must include measurable goals, and there must be continued progress toward functional behavior and termination of treatment. Continued coverage may be denied if positive response to treatment is not evident; and
- The services must be provided by a Qualified Provider. If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- A medication evaluation by a psychiatrist may be required before a Physician can prescribe medication for a psychiatric condition. Periodic evaluations may be requested by the Plan.

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.

- Services provided for conflict between the Covered Person and society that is solely related to criminal activity.

- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases - Clinical Modification (ICD-CM) manual (most recent revision) in the following categories:

  - Personality disorders; or
  - Sexual/gender identity disorders; or
  - Behavior and impulse control disorders; or
  - "V" codes (including marriage counseling).

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay for the following Covered Expenses for a Covered Person, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, the Usual and Customary amount, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of substance use disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered, subject to all of the following:

- The Covered Person must receive the services in person at a therapeutic medical facility; and
- The services must include measurable goals, and there must be continued progress toward functional behavior and termination of treatment. Continued coverage may be denied if positive response to treatment is not evident; and
- The services must be provided by a Qualified Provider. If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located, or a therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry. The attending Physician, psychiatrist, or counselor must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of substance use disorder and chemical dependency disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for the change. Such records must include the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

SUBSTANCE USE DISORDER EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for the following:

- Treatment or care considered inappropriate or substandard as determined by the Plan.

- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

CARE MANAGEMENT

Utilization Management

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and are appropriate to help ensure cost-effective care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

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

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

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

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR CARE MANAGEMENT**

DEFINITIONS

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

Prior Authorization is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for services, tests, or procedures that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay.

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

SERVICES REQUIRING PRIOR AUTHORIZATION

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

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- All Durable Medical Equipment, excluding braces or orthotics.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Outpatient surgery (not performed in a Physician's office).
- Day rehabilitation programs.
- Rehabilitation therapy.
- Physical, speech and/or occupational therapy.
- Hospice Care.
- Cardiac rehabilitation therapy.
- Pain management therapy.
- Diagnostic procedures including but not limited to; cardiac stress test, endoscopic procedures, myelogram, MRI, PET and CT scan.

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

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

The fact that a Covered Person provides Prior Authorization from the Utilization Review Organization, that does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD.

Medical Director Oversight. A UMR Care Management medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

Case Management Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case-to-case management for review. Case management opportunities are identified by using a system-integrated, automated, diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals. Information is easily passed from utilization management to case management through our fully integrated care management software system.

All Prior Authorization requests are used to identify the member's needs. Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted upon request and a determination will be issued within 30 calendar days of the receipt of request within Care Management, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures.

Disease Management Program

The **Disease Management Program** identifies those individuals who have certain chronic diseases and would benefit from this program. Specially trained nurses work telephonically with Covered Persons to help them improve their chronic diseases and maintain quality of life. Our unique approach to Disease Management identifies individuals with one or more of the seven targeted chronic conditions (asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes, hypertension, and depression as a comorbidity linked to another chronic condition we manage). Built within our system is a predictive modeling tool, Aerial Analytics and Clinical Intelligence Rules, that takes up to two years' worth of medical and pharmacy claims data and then identifies those Covered Persons who are eligible to participate in the coaching program. If claims history is not available, Disease Management candidates may be initially identified using a Health Condition Survey. The survey is a general screening questionnaire sent to all Covered Persons age 18 and over that asks a few questions about each of the conditions managed in the program. Once claims data is available, the predictive modeling tool is used to identify candidates for the program. Program participants can also be identified through referrals from the Prior Authorization process, Covered Person self-referrals, other Care Management programs, NurseLine referrals, the employer, or the Covered Person's Physician.

In addition to the telephonic services, UMR Disease Management also provides HealtheNotes. These targeted mailings are sent to Covered Persons' homes and their health care providers via U.S. Mail. They identify chronic condition gaps in care and include information on ways to prevent long-term issues and avoid health care costs. Opportunities or gaps in care are identified through medical and/or pharmacy data.

HealtheNotes provides useful, personalized information based on an individual Covered Person's health care utilization, including information on provider visits, Prescriptions, and health screenings.

HealtheNotes is a vital educational tool in the Disease Management Program for managing a Covered Person's chronic condition(s). It assists in our efforts to significantly improve the quality of life for Covered Persons while simultaneously reducing overall health care costs.

Maternity Management

Maternity Management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full term-deliveries and decreases the cost of a long-term hospital stays for both mothers and babies. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment is performed at that time to determine the member's risk level and educational needs. The program uses incentives in order to increase participation and encourage program completion. UMR's standard incentive is a $25 prepaid reward card to each member who enrolls in the first or second trimester and completes the postpartum coaching call and returns a satisfaction survey. Each Covered Person who enrolls via the web receives a special edition pregnancy information guide. UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they are pregnant. Members self-enroll in the pre-pregnancy coaching program by calling our toll-free number. They are then contacted by nurse case managers who have extensive clinical backgrounds in obstetrics/gynecology. The nurses complete pre-pregnancy assessments to determine risk levels, if any, and provide members with education and materials based on their needs. The nurses also help members understand their Plan's benefit information.

Case Management

Case Management Services are designed to identify catastrophic and complex Illnesses, transplants, and trauma cases. UMR Care Management's nurse case managers identify, coordinate, and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified by using a system-integrated, automated, diagnosis-based trigger list during the prior authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals. UMR Care Management works directly with the patient, the patient's family members, the treating Physician, and the facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious Illness helps avoid major complications in the future. The Covered Person may request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. Prescription drug coverage under Medicare Part D will be coordinated under the Medicare Secondary Payer Rules The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (which is the primary plan). The primary plan pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays for Covered Expenses after the primary plan has processed the claim, and will reduce the benefits it pays so that the total payment between the primary plan and the secondary plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Foreign health care coverage.
- Medical care components of group long-term care contracts, such as Skilled Nursing Care.
- Medical benefits under group or individual motor vehicle policies (including no-fault policies). See the order of benefit determination rules (below).
- Medical benefits under homeowners' insurance policies.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid.

However, this Plan does not coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

Effective July 1, 2006, Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare Part A, if eligible and at no additional cost to the member. Also effective July 1, 2006, Medicare Part B is required and assumed primary for all Retiree participants age 65 and older, unless the participant was grandfathered in by board action per the June 2006 board meeting.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply:

- Any plan that has no coordination of benefits provision is considered primary.

- This Plan will coordinate benefits in a manner that will comply with the Medicare Secondary Payer (MSP) regulations. The following are examples of how the MSP rules work:

  - ➢ If You or Your Dependent is actively employed and covered under an employer's group health plan or policy, the active plan pays first for both the employee and the spouse. Medicare pays second, and any retiree health care coverage would pay third.
  - ➢ If You and Your spouse are retired and age 65 or older, Medicare pays first and any retiree plan pays second.
  - ➢ For a Covered Person with End Stage Renal Disease (ESRD), an employer's group health plan covering active employees has primary responsibility for payment for 30 months from the date the Covered Person has Medicare eligibility based upon ESRD. At the end of 30 months, Medicare becomes the primary plan, any employer group health plan covering active employees would pay second, and any retiree plan would pay third.

- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan will always be considered secondary regardless of the individual's election under Personal Injury Protection (PIP) coverage with the auto carrier.

- The plan that covers a person as an employee, member, or subscriber (that is, other than as a Dependent) is considered primary. The primary plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any employee plan beneficiary to be eligible for primary benefits from his or her employer's benefit plan. Employee plan beneficiaries do not include COBRA Qualified Beneficiaries or Retirees.

- The plan that covers a person as a Dependent is generally secondary. The plan that covers the Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent. (See continuation coverage below.) (There may also be exceptions due to Medicare Secondary Payer Rules.)

- If one or more plans cover the same person as a Dependent Child:

  - ➢ The primary plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
    - If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.

  - ➢ If the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

- If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:

  - The plan of the custodial parent;
  - The plan of the spouse of the custodial parent;
  - The plan of the non-custodial parent; and then
  - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or Dependent of an active employee), and is also covered under another plan as a retired or laid-off employee (or Dependent of a retired or laid-off employee), the plan that covers the person as an active employee (or Dependent of an active employee) will be primary.

- Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary, unless the Medicare Secondary Payer rules require COBRA to be primary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored.

- Longer or Shorter Length of Coverage: The plan that has covered the person as an employee, member, subscriber, or Retiree the longest is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.

- If the above rules do not determine the primary plan, the Covered Expenses may be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

Note: If a Covered Person is eligible for Medicare as his or her primary plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether or not the Covered Person is enrolled in Medicare.

TRICARE

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. Each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT, AND OFFSET

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers' Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - ➢ Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
  - ➢ Providing any relevant information requested by the Plan.
  - ➢ Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.

- Responding to requests for information about any accident or Injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

- By participating in and accepting benefits from the Plan, You agree that:
  - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to Your own negligence.

- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

GENERAL EXCLUSIONS

The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of the Injury when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Abortions,** unless a Physician states in writing that the mother's life would be in danger if the fetus were carried to term.

2. **Acts of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

3. **Acupuncture Treatment.**

4. **Alcohol:** Services, supplies, care or treatment to a Covered Person for an Injury or Illness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for substance use disorder treatment as specified in this Plan. 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. **Alternative Treatment** including treatment, services, or supplies for holistic or homeopathic medicine, hypnosis, or other alternate treatment that is not accepted medical practice as determined by the Plan.

6. **Appointments Missed:** An appointment the Covered Person did not attend.

7. **Assistance With Activities of Daily Living.**

8. **Assistant Surgeon Services,** unless determined to be Medically Necessary by the Plan.

9. **Auto Excess:** Illness or bodily Injury for which there is a medical payment or expense coverage provided or payable under any automobile coverage.

10. **Before Enrollment and After Termination:** Services, supplies, or treatment rendered before coverage begins or after coverage ends under this Plan.

11. **Biofeedback Services.**

12. **Blood:** Blood donor expenses.

13. **Blood Pressure Cuffs / Monitors.**

14. **Cardiac Rehabilitation** beyond Phase II, including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

15. **Chelation Therapy**, except in the treatment of conditions considered to be Medically Necessary, medically appropriate, and not Experimental, Investigational, or Unproven for the medical condition for which the treatment is recognized.

16. **Claims** received after the timely filing deadline.

17. **Close Relative:** Services performed by a Close Relative or by someone who ordinarily lives in the Covered Person's home.

18. **Contraceptive Products**, including medications, devices, patches, or injectables used for birth control.

19. **Cosmetic Treatment, Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

20. **Counseling Services:** Marriage counseling, pastoral counseling, or financial counseling.

21. **Court-Ordered:** Any treatment or therapy that is court-ordered, or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving-while-intoxicated conviction or other classes ordered by the court.

22. **Criminal Activity**: Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony for which the individual is charged.

23. **Custodial Care** as defined in the Glossary of Terms section of this SPD.

24. **Dental Services:**

    - The care and treatment of teeth or gums, alveolar processes, dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges, including professional charges for X-rays, labs, and anesthesia; to charges for treatment of Injuries to natural teeth, including replacement of such teeth with dentures; or to charges for the setting of a jaw that was fractured or dislocated in an Accident.
    - Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
    - Dental implants, including preparation for implants.

25. **Developmental Delays:** Occupational, physical, and speech therapy services related to Developmental Delays, mental retardation, or behavioral therapy. These services are not Medically Necessary and are not considered by the Plan to be medical treatment. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

26. **Duplicate Services and Charges or Inappropriate Billing,** including the preparation of medical reports and itemized bills.

27. **Education:** Charges for education, special education, job training, music therapy, and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

28. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, and vacuum devices.

29. **Examinations:** Examinations for employment, insurance, licensing, or litigation purposes.

30. **Excess Charges:** Charges or the portion thereof that are in excess of the Usual and Customary charge, the Negotiated Rate, or the fee schedule.

31. **Experimental, Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment.

32. **Family Planning**: Consultations for family planning.

33. **Fitness Programs**: General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment, or facilities in connection with weight control or bodybuilding.

34. **Foot Care (Podiatry):** Treatment of Injuries or diseases of the foot, including:

    - Palliative foot care.
    - Trimming of nails, corns, or calluses when there is not a metabolic disease.

35. **Foreign Coverage for Medical Care Expenses, Including Preventive Care or Elective Treatment**, except for services that are Incurred in the event of an Emergency.

36. **Gender Transition:** Treatment, drugs, medicines, services, and supplies for, or leading to, gender transition surgery.

37. **Genetic Counseling** regardless of purpose, unless covered elsewhere in this SPD.

38. **Genetic Testing,** unless covered elsewhere in this SPD.

39. **Hazardous Recreational Activity**: Injuries or Illnesses related to Hazardous Recreational Activities, unless the Injuries or Illnesses are caused primarily as a result of other medical conditions not related to the Hazardous Recreational Activities, or to domestic violence.

40. **Hearing Services:** Implantable hearing devices, unless covered elsewhere in this SPD.

41. **Home Births** and associated costs.

42. **Home Modifications:** Modifications to home or property, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, or ramps.

43. **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Illness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for substance use disorder treatment as specified in this Plan. 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.

44. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.

45. **Infertility Treatment** and direct attempts to achieve pregnancy by any means.

46. **Lamaze Classes** or other childbirth classes.

47. **LASIK Surgery, Radial Keratotomy, Refractive Keratoplasty,** or similar surgery used to improve eyesight or refractive disorders.

48. **Learning Disability:** Non-medical treatment, including, but not limited to, special education, remedial reading, school system testing, and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

49. **Maintenance Therapy** if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve a condition, or if clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

50. **Mammoplasty or Breast Augmentation,** unless covered elsewhere in this SPD.

51. **Maternity Costs** for Covered Persons other than the Retiree, spouse or Dependent daughter(s).

52. **Maximum Benefit:** Charges in excess of the Maximum Benefit allowed by the Plan.

53. **Medicare:** Charges for care and treatment of an Illness or Injury that is not approved by Medicare (except to the extent non-Medicare benefits are specifically provided for on the Schedule of Benefits).

54. **Military:** A military-related Illness of or Injury to a Covered Person on active military duty, unless payment is legally required.

55. **Non-Compliance:** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or skilled nursing facility against medical advice.

56. **Non-Custom-Molded Shoe Inserts**.

57. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.

58. **No Physician Recommendation:** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care or a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.

59. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities, or equipment that reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy above.

60. **Nutrition Counseling,** unless covered elsewhere in this SPD.

61. **Nutritional Supplements, Vitamins, and Electrolytes** except as listed under Covered Medical Benefits.

62. **Orthopedic Shoes.**

63. **Over-The-Counter Medication**, **Products, Supplies, or Devices,** unless covered elsewhere in this SPD.

64. **Panniculectomy / Abdominoplasty,** unless determined by the Plan to be Medically Necessary.

65. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as, but not limited to, private rooms, televisions, telephones, and guest trays.

66. **Private Duty Nursing Services.**

67. **Reconstructive Surgery** performed only to achieve a normal or nearly normal appearance, or any portion thereof, as determined by the Plan, except as required under the Women's Health and Cancer Rights Act.

68. **Return to Work / School:** Telephone or Internet consultations, or the completion of claim forms or forms necessary for a return to work or school.

69. **Reversal of Sterilization**: Procedures or treatments to reverse prior voluntary sterilization.

70. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgery Center.

71. **Self-Administered Services** or procedures that can be performed by the Covered Person without the presence of medical supervision.

72. **Services at No Charge or Cost**: Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense code, or as required by law.

73. **Services Provided By a Close Relative.** See the Glossary of Terms section of this SPD for a definition of Close Relative.

74. **Services** that should legally be provided by a school.

75. **Sex Therapy.**

76. **Sex Transformation:** Treatment, drugs, medicines, services, and supplies for, or leading to, sex transformation surgery.

77. **Sexual Function:** Diagnostic services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Drug Benefits section of this SPD) in connection with treatment for male or female impotence.

78. **Skilled Nursing Care:** Any Skilled Nursing Facility services that exceed the appropriate level of skill required for treatment as determined by the Plan.

79. **Standby Surgeon Charges.**

80. **Surrogate Parenting and Gestational Carrier Services:** Any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.

81. **Taxes:** Sales taxes and shipping and handling charges, unless covered elsewhere in this SPD.

82. **Telemedicine - Telephone or Internet Consultations,** except as approved by Medicare.

83. **Tobacco Addiction:** Diagnoses, services, treatment, or supplies related to addiction to or dependency on nicotine.

84. **Transportation:** Transportation services that are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

85. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.

86. **Vitamins, Minerals, and Supplements**, even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.

87. **Vision Care:** Routine eye care or the purchase or fitting of eyeglasses or contacts, except as allowed by Medicare following cataract surgery.

88. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes.

89. **Warning Devices:** Warning devices, stethoscopes, and other types of apparatus used for diagnosis or monitoring.

90. **Weekend Admissions** to Hospital confinement (admissions taking place after 3:00 pm on Fridays or before noon on Sundays) unless the admission is deemed an Emergency, or is for care related to a covered pregnancy that is expected to result in childbirth.

    Non-Emergency Hospital admissions are care and treatment billed by a Hospital for non-medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

91. **Weight Control:** Treatment, services, or surgery for weight control**,** whether or not prescribed by a Physician or associated with an Illness.

92. **Workers' Compensation**: Any Illness or Injury arising out of, or in the course of, any employment for wage or profit, including self-employment, for which the Covered Person was or could have been entitled to benefits under any Workers' Compensation, U.S. Longshoremen and Harbor Workers', or other occupational disease legislation, policy, or contract, whether or not such policy or contract is actually in force.

93. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as required by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to obtain approval from the Plan ***before*** obtaining medical care, such as in the case of prior authorization of health care items or services that the Plan requires. Generally, if a claim has been paid by Medicare, prior authorization is not necessary. If a Covered Person or provider calls the Plan for the sole purpose of learning whether or not a claim will be covered, that call is not considered a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization. Obtaining prior authorization does not guarantee that the Plan will ultimately pay the claim.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept Assignment and coordinate payment directly with Medicare on the Covered Person's behalf. If the Covered Person gives UMR his or her Medicare identification number, Medicare will automatically send information to UMR stating how much Medicare has paid toward Covered Expenses, and how much the Covered Person is responsible for paying. If Medicare states that the Covered Person owes a certain amount toward the bill, then UMR will process the claim according to the provisions in this document to see if this Plan can help cover some of the Covered Person's remaining costs.

If the provider will not accept Assignment or coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

A Covered Person who receives services in a country other than the United States is responsible for ensuring the provider is paid. The Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Person for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if the paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, Social Security number, address, and relationship to Retiree
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services, or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider's billing name, address, and telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto Accident, or another Accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Complete claims must be submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. A complete claim means that the Plan has all of the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

HOW HEALTH BENEFITS ARE CALCULATED

When UMR receives a claim for a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If the service is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If the service is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

If Medicare approves a claim, this Plan will use not more than 100% of the Medicare-Approved Amount as the starting point when determining how much this Plan will pay toward that claim, if anything. If Medicare does not approve a claim, this Plan pays Covered Expenses according to an established fee schedule, according to a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

Fee Schedule: Generally, a provider is paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible or other out-of-pocket expenses that the Covered Person is responsible for paying, and subject to the Coordination of Benefits provision.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service, such as transplant services, Durable Medical Equipment, Extended Care Facility treatment, or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Deductible or other out-of-pocket expenses that the Covered Person is responsible for paying, and subject to the Coordination of Benefits provision.

Usual and Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area for the same services, treatment, or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 85th percentile. The U&C guidelines do not apply to in-network claims, which are governed by the network contract. The allowable amounts are then processed according to Plan provisions. A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties, or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears to be correct. If You have any questions or concerns about the EOB form, call the Plan at the number listed on the EOB form or on the back of the group health identification card. The provider will receive a similar form for each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although a Covered Person may voluntarily extend these timelines:

- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the treatment authorization ending or being reduced.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- A Covered Person's loss of eligibility for coverage under the health Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group health Plan.
- Termination of the group health Plan.
- The Covered Person or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Covered Person is responsible for charges due to Deductible or other out-of-pocket expense obligations.
- Application of the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Procedures are considered Experimental, Investigational, or Unproven.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied, in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person may take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his or her Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is an Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or his or her Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 60 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume that the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his or her rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal, including applicable rules, a Covered Person's right to representation (i.e., to appoint a Personal Representative), or other details, please contact the Plan.

Appeals should be sent within the prescribed time period as stated above to the following address(es):

Note: Post-Service Appeal Request forms are available at www.UMR.com to assist You in providing all the recommended information to ensure a full and fair review of Your adverse benefit determination. You are not required to use this form.

Send Post-Service Claim Medical appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

Send Pre-Service Claim Medical appeals to:
UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

This Plan contracts with various companies to administer different parts of this Plan. A Covered Person who wants to appeal a decision or a claim determination that one of these companies made should send appeals directly to the company that made the decision being appealed.

Send Pharmacy appeals to:
SOUTHERN SCRIPTS
PO BOX 2482
NATCHITOCHES LA 71457

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claims: Within a reasonable period of time appropriate to the medical circumstances, but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claims: Within a reasonable period of time, but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else -- such as the Covered Person's spouse or another family member -- files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan administrator to request a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for a Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

This group health Plan also complies with the provisions of the:

- Americans With Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- Genetic Information Non-discrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care, or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations that it performs on behalf of this Plan.

This Plan agrees that it will Disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- 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 it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

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

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

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

- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

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

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following employees, classes of employees, or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Chief Financial Officer, Accountant, Bookkeeper

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

DEFINITIONS

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

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

Business Associate (BA) in relationship to a Covered Entity (CE) means a person to whom the CE Discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

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

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

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

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

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;

- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

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

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

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or it's Business Associate that obtains reimbursement for the provision of health care.

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

Plan Sponsor means Your employer.

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

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy, will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen, and unintended event that causes bodily harm or damage to the body.

Activities Of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation, or when deemed Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Ancillary Services means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency, including the following: ambulance services, anesthesiology, assistant surgeon services, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

Birthing Center means a legally operating institution or facility that is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Assignment (in the original Medicare Plan) means that the Covered Person's Part B provider has agreed to accept the Medicare-Approved Amount as payment in full. The Covered Person still needs to pay any applicable Deductible and Plan Participation amounts. If a provider does not accept Assignment, the Covered Person may pay more for services.

Benefit Period means the period beginning on the day You are admitted to a Hospital or skilled nursing facility and ending when You have not received any Hospital or Skilled Nursing Facility Care for 60 consecutive days. If You are admitted to a Hospital or skilled nursing facility after one Benefit Period has ended, a new Benefit Period begins.

Child (Children) means any of the following individuals with respect to a Retiree: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Retiree's or spouse's Legal Guardianship; a grandchild, as long as the Retiree's covered Dependent is the parent of the grandchild; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes the Retiree, spouse, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, stepchildren, and grandchildren.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a Qualifying Event.

Common-Law Marriage means a partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

Cosmetic Treatment means medical or surgical procedures that are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expense means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan.

Covered Person means a Retiree or Dependent who is enrolled under this Plan.

Custodial Care means non-medical care given to a Covered Person, such as administering medication and assisting with personal hygiene or other Activities of Daily Living, rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce a disability or improve a condition of a Covered Person.

Deductible means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see the Eligibility and Enrollment section of this SPD.

Developmental Delays means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills. Developmental Delays may not necessarily have a history of birth trauma or other Illness that could be causing the impairment, such as a hearing problem, mental Illness, or other neurological symptoms or Illness.

Durable Medical Equipment means equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- It is generally not useful to a person in the absence of an Illness or Injury.
- It is appropriate for use in the Covered Person's home.

A cochlear implant is not considered Durable Medical Equipment.

Effective Date means the first day of coverage under this Plan as defined in this SPD.

Emergency means a serious medical condition with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Experimental, Investigational, or Unproven means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);

- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;

- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;

- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care, or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology,™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility means a facility including, but not limited to, a skilled nursing, rehabilitation, convalescent, or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full-time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: provide 24-hour-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; require compensation from its patients; admit patients only upon Physician orders; have an agreement to have a Physician's services available when needed; maintain adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provide the services to which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Hazardous Recreational Activity means an activity such as one of the following when engaged in by a Covered Person knowingly and voluntarily and in a manner that reasonably could be recognized as an organized leisure time pursuit:

- Competitive boxing.
- Bungee-cord jumping.
- Flight in ultralight or Experimental aircraft.
- Handling or use of illegal explosives.
- Handling of poisonous insects, reptiles, or amphibians.
- Hang-gliding.
- Competitive martial arts.
- Parachuting.
- Competitive racing of any motorized vehicle.
- Skydiving.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

Home Health Care means a formal program of care and intermittent treatment that is: performed in the home; prescribed by a Physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or an Extended Care Facility stay or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means Intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in an Inpatient setting for a Covered Person suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospital means a facility that:

- Is licensed as an acute Hospital; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Always provides 24-hour nursing services by registered graduate nurses; and
- Is not a place primarily for maintenance or Custodial Care.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Imaging means the action or process of producing an image of a part of the body by radiographic techniques using high-end radiology such as MRA, MRI, CT, or PET scans and nuclear medicine.

Incurred means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Infertility Treatment means services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is performed in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to, fertility tests and drugs; tests and exams performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm-enhancement procedures; direct attempts to cause pregnancy by any means, including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; gamete intrafallopian transfer (GIFT) or zygote intrafallopian transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas, including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Lifetime Maximum Benefit means maximum amount of Covered Benefits payable while a person is covered under this Plan. When the Lifetime Maximum Benefit is met, a Covered Person is no longer eligible for benefits under this Plan. The term "Lifetime" does not mean during the lifetime of the Covered Person.

Manipulation means the act, process, or instance of manipulating a body part by manual examination and treatment, such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

Maximum Benefit means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

Medically Necessary / Medical Necessity means treatment, services, supplies, medicines, or facilities necessary and appropriate for the diagnosis, care, or treatment of an Illness or Injury that meet all of the following criteria as determined by the Plan:

- The health intervention is for the purpose of treating a medical condition; and
- It is the most appropriate supply or level of service, considering potential benefits and harms to the patient; and
- It is known to be effective in improving health outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, and finally by expert opinion; and
- It is cost-effective for a specific condition, compared to alternate interventions, including the option of no intervention. The term "cost-effective" does not necessarily mean for the lowest price; and
- It is not primarily for the convenience or preference of the Covered Person, for the Covered Person's family, or for any provider; and
- It is not Experimental, Investigational, cosmetic or custodial in nature; and
- It is currently, or at the time the charges were Incurred, recognized as acceptable medical practice by the Plan.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or the fact that such service, treatment plan, supply, medicine, equipment, or facility is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

Medicare means the program of medical care benefits provided under Title XVIII of the United States Social Security Act, as amended.

Medicare-Approved Amount means the fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by You and Medicare for a service or supply. It may be less than the actual amount charged by the doctor or supplier. The approved amount is sometimes called the "approved charge."

Mental Health Disorder means a disorder that is a clinically significant psychological syndrome associated with distress, dysfunction, or Illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, Illness or death.

Morbid Obesity means the Covered Person's Body Mass Index (BMI) is above 40 and at least three (3) of the following are met:

- Your Physician documents You are greater than 100 pounds over Your expected weight for height and stature;
- You have cardiovascular disease requiring medication;
- You have degenerative arthritis with documented functional limitations;
- You have obstructive pulmonary disease.

Additionally, any bariatric surgery performed to treat Morbid Obesity requires all of the above, and

- Documentation from Your Physician that You have tried for a minimum of six months and failed a medically guided weight loss program; and
- A psychologist, a dietician, an exercise physiologist and surgeon confirm in writing You have met with them and that You are physically and mentally prepared to undergo the proposed bariatric surgery, a structured post-operative exercise program and follow-up program; and
- You must provide the following documentation:

  - You have a complete understanding of any bariatric procedure You are requesting benefits for, the risks and limitations associated with the procedure and lifelong changes in eating habits that will be required;
  - You have the support of Your immediate family and the support of Your personal physician; and
  - A description of the structured post-operative exercise and follow-up program You are committing to participate in after surgery.

Negotiated Rate means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, or too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliance means a brace, splint, cast, or other appliance that is used to support or restrain a weak or deformed part of the body, that is designed for repeated use, that is intended to treat or stabilize a Covered Person's Illness or Injury or improve function, and that is generally not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services, or supplies in a facility in which a patient is not registered as a bed patient and for whom room and board charges are not Incurred.

Physician means any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this Plan: a doctor of medicine (MD); doctor of medical dentistry, including an oral surgeon (DMD); osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT), or a physician's assistant (PA), or a nurse practitioner (NP), or a certified nurse midwife (CNM); or a certified registered nurse anesthetist (CRNA). The term Physician also may include, at the Plan Sponsor's discretion, other licensed practitioners who are regulated by a state or federal agency, who perform services payable under this Plan, and who are acting within the scope of their license, unless specifically excluded by this Plan.

Placed for Adoption / Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the ST. MARTIN PARISH SCHOOL BOARD HEALTH BENEFIT PLAN Medicare Supplement Group Health Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug, that could be a medication or supply for the person for whom prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom prescribed. It must also identify the name, strength, quantity and the directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened. Benefits included as Preventive / Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive / Routine Care is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury.

Qualified means licensed, registered, or certified by the state in which the provider practices.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

Retiree shall mean an Employee who was a covered Employee, as defined by the terms of this document, immediately prior to the date of retirement.

Skilled Nursing Facility Care means an institution that has a transfer agreement with one or more Hospitals. For the most part, it provides inpatients with skilled nursing care and related services. The facility must be licensed by the state in which it operates as a Skilled Nursing Facility. Any service that could be safely done by an average non-medical person (or by one's self) without the supervision of a registered nurse is not considered skilled care.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever the patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well being of the patients;

- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications.

Temporomandibular Joint Disorder (TMJ) means a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) means a service provider hired by the Plan to process claims, and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled as used in this SPD means a condition of a Dependent Child who has been deemed unable to hold a self-sustaining job due to a disability.

That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross section of accurate data.

You / Your means the Retired person.