Summary Plan Description

Medical and Prescription Benefits

Effective: January 1, 2012
Benefit Year: January 1 – December 31

Final

The benefits described in this SPD are part of the Monterey Peninsula College Self-Funded Medical Plan (#501). The Plan Year is July 1 – June 30. All changes to achieve compliance with federal regulations under the Patient Protection and Affordable Care Act as a non-grandfathered health plan have been incorporated into this document.

Monterey Peninsula College is proud to provide you with the following health care coverage:

- A **Medical** plan that provides benefits for preventive care, hospital stays, emergency room care and mental health/substance abuse treatment.
- When you enroll in the medical plan you are also enrolled for **Prescription** benefits plan, for both short-term and long-term medicines.

This Summary Plan Description (SPD) is divided into three sections:

- **Eligibility and Enrollment Information** explains how to enroll for benefits, your cost for coverage and when you can change your or your dependents' coverage.
- **Description of Benefits** covers the major features of the medical and prescription benefit plans, as well as limitations and/or exclusions of the plans.
- **General Facts** discusses how to apply for benefits, situations that may affect your benefits, how the plans operate and your legal rights under the plan.

Take time to read this material carefully and share it with your family. If you have any questions about your coverage, contact your Human Resources representative.

Note: The standards for coverage of medical expenses change from time to time. You will receive periodic notices of important changes or modifications to the plans (to the extent that they are inconsistent with the benefits described in this SPD). However, all changes to covered benefits are binding, as long as employees are provided with advance notice of the changes, as required by federal law.

IMPORTANT: The Monterey Peninsula College Self-Funded Medical Plan is **not a** plan that requires compliance with the Employee Retirement Income Security Act of 1974 (ERISA).

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DIRECTORY OF SERVICE PROVIDERS

The following providers render services on behalf of the Plan. A Plan participant can contact the appropriate office when he/she has a question or needs help.

Type of Service	Provider
Plan Sponsor	**Monterey Peninsula College** 980 Fremont Street Monterey, California 93940 (831) 645-1392
Utilization Management Administers the **Utilization Management Program** (pre-admission and review requirements, etc.).	**Anthem Blue Cross** (800) 274-7767 www.anthem.com/ca
Contract Administrator for Medical Benefits See **General Facts** for additional information. Address for claims appeals:	**Delta Health Systems** P.O. Box 702500 West Valley City, UT 84170 www.deltahealthsystems.com **Delta Health Systems** P.O. Box 80 Stockton, CA 95201
Contract Administrator for Prescription Benefits	**Express Scripts** P.O. Box 66583 St. Louis, MO 63166 Customer Service: (866) 294-1565 For specialty medications: (888) 773-7376 www.express-scripts.com
Preventive Care Guidelines	**U.S. Preventive Task Force** www.healthcare.gov/center/regulations/prevention/taskforce.html **Centers for Disease Control and Prevention** www.cdc.gov/vaccines/recs/schedules/#child **Health Resources and Services Administration** www.hrsa.gov/womensguidelines/

Eligibility & Enrollment Information

ELIGIBILITY

Employee Eligibility Requirements

You may enroll in the plan if you are ***eligible***, as defined by:

- Monterey Peninsula College, or
- the terms of an applicable collective bargaining agreement.

Contact Human Resources if you need additional information about eligibility requirements.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified. *Note: Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.*

Active Employment

You will be deemed in active employment on:

- each day you are actually performing services for the Employer,
- on each day of a regular paid leave or on a regular non-working day, provided you were actively at work on the last preceding regular working day, and
- any day on which you are absent from work during an approved FMLA leave or solely due to your own health status (see *Non-Discrimination Due to Health Status* in the **General Plan Information** section).

An exception applies only to your first scheduled day of work. If you do not report for employment on your first scheduled workday, you will not be considered as having commenced active employment.

Dependent Eligibility Requirements

An eligible Dependent of an Employee is:

- ***A legally married spouse.***
- ***A registered domestic partner*** as defined in California Family Code Section 297 with a legally executed Declaration of Domestic Partnership filed with the California Secretary of State.
- ***A child of the employee, his/her eligible spouse or domestic partner, up to age 26***. For these purposes a "child" will include:
    - a natural child,
    - a stepchild,
    - foster children (a child placed under the court-appointed legal guardianship of the Employee or the Employee's spouse),
    - a child who is adopted by the Employee or placed with him for adoption. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun,
    - a child for whom Plan coverage is required due to a Medical Child Support Order (MCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and that satisfies the QMCSO requirements of ERISA. A child who is the subject to a QMCSO need not be a Tax Code dependent of the Employee.
- ***A disabled child age 26 or older***, as long as he/she is:
    - unmarried,
    - primarily dependent on the employee for support, and

- continues to meet the following conditions, as defined by Section 12102 of the Americans with Disabilities Act (ADA):
    - a physical or mental impairment that substantially limits one or more major life activities of such individual,
    - a record of such impairment, or
    - being regarded as having such impairment.

  In accordance with ADA, the term disability shall **not** include:
    - transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments or other sexual behavior disorders,
    - compulsive gambling, kleptomania or pyromania, or
    - psychoactive substance use disorders resulting from current illegal use of drugs.

Proof of Dependent Status

You may be required to provide the following proof that a spouse or child is a dependent (i.e., certified marriage license, birth certificate, etc.) upon enrollment and/or on an annual basis.

For disabled children, proof must be provided to the Contract Administrator within 31 days of the child's attainment of the limiting age, and thereafter as may be required, but not more frequently than once a year after the two year period following the child's attainment of such age. In addition, MPC reserves the right to have any such dependent examined by a physician of MPC's choice, at the plan's expense, to determine the existence of such incapacity.

Important: MPC reserves the right to terminate coverage, on a retroactive basis, if there is an intentional misrepresentation of dependent status; for additional information, see *Termination for Fraud* under the *Termination of Coverage* section.

Non-Eligible Dependents

The following dependents are not eligible:

- a spouse following a:
    - court order as part of a legal separation that specifies termination of health care benefits, or
    - final decree of dissolution or divorce, or
- any person who is on active duty in a military service, to the extent permitted by law.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Dual Coverage

If ***you and your spouse*** are both eligible under this plan as an Employee, then:

- you and your spouse may be covered as both an employee and your spouse's dependent, and
- your dependent children may be covered by both parents.

WHEN YOU CAN ENROLL AND EFFECTIVE DATE OF COVERAGE

The following chart outlines when you and your dependents can enroll for benefits, as well as when coverage begins (Effective Date of Coverage):

When You Can Enroll	Effective Date of Coverage
New Hire ***Important:*** When you enroll as a new hire, you and your dependents may be subject to a pre-existing condition limitations; see *Coverage Limitations for Pre-Existing Conditions* for additional information.	On the first day of the month following the date your eligible employment begins ***if*** you complete and return the enrollment form within 31 days of this effective date. _____ **If you do not enroll within 31 days:** Your next opportunity to enroll yourself and your dependents will be following a qualified life event, as described under *Changing Coverage During the Year*. In addition, you and your dependents may be subject to a pre-existing condition; see Coverage *Limitations for Pre-Existing Conditions* for additional information.
During the Year, if you have a qualifying: ▪ change in status event, or ▪ event that provides you with special enrollment rights See Changing Elections During the Year for details ***Important:*** If you enroll during the year, you and your dependents may be subject to a pre-existing condition limitation; see *Coverage Limitations for Pre-Existing Conditions* for additional information.	For a newborn infant, adopted child or a child placed for adoption or foster child, coverage is effective the date of your qualifying event ***if*** you complete and return the enrollment form within 31 days of the event. For all other qualifying events, including marriage, coverage is effective on the first day of the month following the date of the qualifying event ***if*** you complete and return the enrollment form within 31 days of the event. _____ **If you do not change your coverage within 31 days**: Your next opportunity to make a change will be following a qualified life event, as described under *Changing Coverage During the Year.* In addition, you and your dependents may be subject to a pre-existing condition; see Coverage *Limitations for Pre-Existing Conditions* for additional information.
Dependents	▪ In no instance will a dependent's coverage become effective prior to the employee coverage effective date. ▪ A dependent who is eligible and enrolled when the employee enrolls, will have coverage effective on the same date. ▪ Dependents acquired later may be enrolled within 31 days of their eligibility date (see *Special Enrollment Rights* on for additional information). ▪ Otherwise, a dependent can be enrolled as described under *During the Year*. ▪ Dependents may be subject to a pre-existing condition limitation; see *Coverage Limitations for Pre-Existing Conditions* for additional information.

As a new hire, you will receive an enrollment form listing all of the plans for which you are eligible to enroll. When you experience a qualifying event, you must contact Human Resources to receive a status change form.

Specific information about each enrollment opportunity is provided below and on the following pages.

Declining Coverage

If an Employee does not wish to participate in the Plan, he/she must decline coverage, in writing, by completing a waiver form. If neither an enrollment card nor a waiver card is submitted, a declination of coverage is assumed.

In this situation**,** you will not have the opportunity to enroll in the future unless you experience a qualifying event during the year.

New Hire

As a new hire, to receive the coverage you want, **you have 31 days from your date of hire to**:

- enroll yourself and your eligible dependent(s), and
- submit all required documentation.

If you **do not complete the entire process within 31 days of your hire date,** you will not have the opportunity to enroll in the future unless you experience a qualifying event; see *During the Year* below for additional information.

During the Year

You may experience certain events during the plan year that would allow you to change your medical coverage. If such an event occurs, **you must change your benefit coverage within 31 days of the event**.

If you do not change your coverage within 31 days, your next opportunity to make a change will be following the next occurrence of a qualifying life event.

There are two sets of regulations, established by the Federal government, that control the types of coverage changes you can make during a plan year. The regulations, as outlined on the following page, classify the changes as follows:

- **Change in Status Events** (as provided by the Internal Revenue Code). The government has established rules that control when you can change or enroll for coverage. Based on your situation, you may be able to:
    - **change** your coverage during the plan year (i.e., add or remove dependents to your existing coverage), or
    - **late enroll**, which refers to enrolling yourself and/or your dependents for coverage during the plan year, even though you declined coverage when you were first eligible. *Note: You must enroll for coverage in order to enroll your dependents.*
- **Special Enrollment Rights** (as provided by the Health Insurance Portability and Accountability Act – HIPAA). Under certain circumstances, even if you or your eligible dependents are not currently enrolled in a plan, the government requires that you and your eligible dependents be allowed to **late enroll** – enroll during the plan year even though you declined coverage when you were first eligible. *Note: You must enroll for coverage in order to enroll your dependents.*

Important: The information on the following page is a summary of when you can change coverage during the year; specific requirements and regulations can be found under Section 125 of the Internal Revenue Code.

Changing Coverage During the Year
Change In Status Events: As provided by the Internal Revenue Code **Enrollment Requirements**: You must change (enroll/drop) coverage **within 31 days** of the following events
▪ Change in your legal marital or domestic partner status, including marriage, death of your spouse/domestic partner, divorce, legal separation or annulment. ▪ Change in the number of your dependents, including birth, adoption, placement for adoption or death of your dependent. ▪ Change in your employment status, including termination or commencement of employment of you, your spouse, your domestic partner or your dependent. ▪ Change in work schedule for you or your spouse/domestic partner, including an increase or decrease in the number of hours of employment, a switch between full-time and part-time status, a strike, lockout or commencement or return from an unpaid leave of absence. ▪ Your dependent satisfies or no longer meets the eligibility requirements for dependents, as described under *Who Is Eligible*, including age. ▪ A change in the place of residence or worksite of you or your spouse/domestic partner *(Note: This move must affect your coverage options).* ▪ You, your spouse/domestic partner or your dependents lose COBRA coverage. ▪ You, your spouse/domestic partner or your dependents enroll for Medicare or Medicaid or lose coverage under Medicare or Medicaid. ▪ If the plan receives a decree, judgment or court order, including a QMCSO pertaining to your dependent, you may add the child to the plan (if the decree, judgment or court order requires coverage) or drop the child from the plan (if the ex-spouse/domestic partner is required to provide coverage). ▪ A significant change in benefit or cost of coverage for you or your spouse/domestic partner. ▪ Your spouse/domestic partner's employer provides the opportunity to enroll or change benefits during an open enrollment period.

Special Enrollment Rights: As provided by HIPAA	**Enrollment Requirements:** You must change (enroll/drop) coverage within:
▪ You initially declined coverage under the plan because you had coverage under another plan, and subsequently incurred a loss of coverage under the other plan*	31 days of the event
▪ Occurrence of certain events such as birth, adoption, placement for adoption or marriage**	31 days of the event
▪ Eligibility for state premium subsidies under Medicaid or the Children's Health Insurance Program	60 days of the event
▪ Loss of coverage under Medicaid or the Children's Health Insurance Program	60 days of the event

** Loss of coverage means:*

- *COBRA coverage has been exhausted for reasons other than non-payment of premiums or fraud, or*
- *loss due to legal separation, divorce, death, termination of employment or reduction in the number of hours of employment.*

*** There is no requirement that protected individuals in this category must have had other coverage prior to the existence of their special enrollment rights.*

Qualified Medical Child Support Order (QMCSO)

Under certain circumstances, in compliance with federal law, MPC provides immediate coverage for your children when you and your spouse legally separate or become divorced. The process begins when MPC receives a QMCSO. A QMCSO is any valid judgment, decree or order, including approval of a settlement agreement, that:

- comes from a court of competent jurisdiction pursuant to a state's domestic relations law,
- requires you to provide group health coverage available under the plans for your children, even though you no longer have custody, and clearly specifies:
  - your name and last known mailing address and the names and addresses of each child covered by the order,
  - a reasonable description of the coverage to be provided,
  - the length of time the order applies, and
  - each plan affected by the order.

If the QMCSO meets the above requirements, the Plan Sponsor will provide a written notification to you, and each child identified in the court order, of eligibility requirements under the plans. This notice will include any required enrollment material, a description of the procedures to be followed and a form for designating the child's custodial parent or legal guardian as his or her representative for all plan purposes. The child's custodial parent, legal guardian or a state agency can apply for coverage even if you do not.

Reinstatement / Rehire

You will be entitled to reinstatement/rehire if you return to active employment and eligible status following an approved leave of absence.

- ***During a Paid Leave Of Absence:*** MPC will continue to pay for benefits for you and your dependents.

- ***During an Unpaid Leave of Absence:*** To continue coverage during your absence, the cost of coverage must be paid according to applicable policies and/or collective bargaining agreement. If there is a lapse in coverage due to failure to pay, benefits will be reinstated upon your return; however coverage is subject to meeting all eligibility requirements as provided by MPC or by the terms of an applicable collective bargaining agreement.

Coverage Limitations for Pre-Existing Conditions

As a new hire and during a late enrollment, you and your dependents may be subject to a pre-existing condition limitations, as outlined below.

Definition of a Preexisting Condition

For Plan purposes, a "preexisting condition" is an illness or injury for which **medical advice, diagnosis, care or treatment** was recommended or received during the 90 days before an **individual's effective date**.
Note: See Exceptions to Pre-Existing Conditions below *for when this limitation is not applicable.*

In further defining the information above:

- Medical advice, diagnosis, care or treatment must have been received from a health care provider or practitioner duly licensed to provide such care under state law and who is operating within the scope of practice authorized by applicable state law.

- An individual's "enrollment date" is the first day of Plan coverage or, if there is a pre-existing limitation for coverage, the first day after the period of limitation.

If you or your dependents are subject to a pre-existing condition limit, the Plan will not pay benefits for the pre-existing condition until you or your dependent have been continuously covered under this Plan for six (6) months (from the first day of Plan coverage); however, the pre-existing condition limit may be reduced if an individual can provide proof of prior coverage (see *Certificate of Creditable Coverage* below for details).

Exceptions to Pre-Existing Conditions

There will be no pre-existing condition limitation imposed under the following circumstances:

- employees or children under the age of 19,
- pregnancy, regardless of the date of conception, diagnosis or first treatment, or
- genetic information in the absence of a diagnosis of a condition related to the genetic information.

Note: These pre-existing condition limitations are intended to comply with at least the minimum requirements of the Health Insurance Portability and Accountability Act of 1996 (H.R. 3103) and Final Regulations; if they are incomplete or in conflict with the law, the law will prevail.

Proof of Creditable Coverage

Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), this is called a certificate of creditable coverage or certificate of group health plan coverage. If this Plan coverage or COBRA continuation coverage terminates, the Contract Administrator will automatically provide a certificate of creditable coverage at no charge; it will be mailed to the person at the most current address on file.

A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within 24 months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Administrator.

TERMINATION OF COVERAGE

For information about continuing medical benefits after termination, see *Extension of Coverage* and/or *COBRA Continuation Coverage*. **Important:** An employee or dependent otherwise eligible and validly enrolled under the plan shall not be terminated from the plan solely due to his/her health status or need for health services.

Employee Coverage Termination

The following chart outlines the events and timing under which coverage will end.

Upon the earliest of the date:	Last Day of Coverage
Events ▪ Termination of the Plan or termination of these Plan benefits. ▪ Termination of participation in the Plan by the Employee. ▪ The date the Employee begins active duty service in the armed services of any country or organization, except for reserve duty of less than 31 days. See the "Extension of Coverage During U.S. Military Service" in the *Extensions of Coverage* section for more information. ▪ The end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost). ▪ When the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in *Eligibility and Effective Dates* section - except when coverage is extended under the *Extensions of Coverage* section. ▪ The date the Employee dies.	Midnight on the last day of the month or applicable CBA
Fraud See *Termination for Fraud* on the following page for additional information	Retroactive back to the date of the initial fraudulent act

Important: Unused vacation days or severance pay following cessation of active work will NOT count as extending the period of time coverage will remain in effect.

Dependent Coverage Termination

The following chart outlines the events and timing under which coverage will end.

Upon the earliest of the date:	Last Day of Coverage
Events ▪ Termination of the Plan or discontinuance of Dependent coverage under these Plan benefits. ▪ Termination of the coverage of the Employee. ▪ When the Dependent ceases to meet the eligibility requirements of these Plan benefits, except when coverage is extended under the **Extensions of Coverage** section. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee. ▪ The end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage that will take effect immediately upon termination.	Midnight on the last day of the month or applicable CBA
Fraud See *Termination for Fraud* ` for additional information	Retroactive back to the date of the initial fraudulent act

Termination for Fraud

An individual's Plan coverage or eligibility for coverage may be terminated if:

- the individual submits any claim that contains false or fraudulent elements under state or federal law,
- a civil or criminal case finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law,
- an individual has submitted a claim which, in good faith judgment and investigation, he/she knew or should have known, contained false or fraudulent elements under state or federal law, or
- it is determined that the Employee or dependent intentionally misrepresented a material fact that resulted in:
    - enrolling a non-eligible dependent for coverage, or
    - failing to remove a non-eligible dependent for coverage.

In the situations outlined above, your dependent's coverage will terminate retroactively to the date of the initial fraudulent act. You may be required to reimburse all claim payments issued from the date of the initial fraudulent act.

For additional information, see the *Subrogation and Reimbursement Provisions* and *Misstatement/Misrepresentation (Intentional)* under *Administrative Information* in the *General Facts* section.

EXTENSION OF COVERAGE

Coverage may be continued beyond the **Termination of Coverage** date (as listed above and on the previous page) in the circumstances identified in this section. Unless expressly stated otherwise, however, coverage for a Dependent will not extend beyond the date the Employee's coverage ceases. For information about continuing medical benefits after an extension of coverage ends, see *COBRA Continuation Coverage*.

Important: An employee or dependent otherwise eligible and validly enrolled under the plan shall not be terminated from the plan solely due to his/her health status or need for health services. In addition, all extended coverage allowances will be provided on a non-discriminatory basis.

During Absence From Work

If you fail to continue in active employment but are not terminated from employment (e.g., your absence is due to an approved leave, a temporary layoff, etc.), you may be permitted to continue health care coverage for yourself and your Dependents. *Note: You may be required to pay the full cost of coverage during such absence.*

Leaves of absence fall into one of two different categories:

- Family and Medical Leave Act (FMLA), and
- All Others (Non-FMLA).

FMLA

To the extent that the Employer is subject to FMLA, it intends to comply with the Act. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, an Employee is entitled to continued coverage if he/she: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Continued coverage under the FMLA is allowed for up to 12 workweeks of unpaid leave in any 12-month period (except as noted otherwise). Such leave must be for one or more of the following reasons:

- the birth of an Employee's child and in order to care for the child,
- the placement of a child with the Employee for adoption or foster care,
- to care for a spouse, child or parent of the Employee where such relative has a serious health condition,
- Employee's own serious health condition that makes him/her unable to perform the functions of his or her job, or
- the Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (a specified military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. This information is a summary of FMLA requirements. An Employee can obtain a more complete description of his/her FMLA rights from the Human Resources Department. Any Plan provisions which are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

If an Employee does not return to his/her regular employment at the end of the FMLA, he/she may be required to refund the Employer any and/or all premiums on a retroactive basis.

FMLA and Servicemembers

An eligible Employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered servicemember. A "covered servicemember" is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is an outpatient, or is on the temporary disability retired list, for a "serious injury or illness" (an injury or illness incurred in line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform his or her duties).

Non-FMLA

If a leave of absence is not taken in accordance with an FMLA provision, coverage which is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

- on the date coverage terminates as specified in the Employer's personnel policies or other employee communications, if any,
- the end of the period for which the last contribution was paid, if such contribution is required, or
- the date of termination of the Plan or these benefits of the Plan.

During U.S. Military Service

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

- ***Notice Requirements*:** To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of his/her military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

  If the Employee provides the Employer with advance notice of his/her military service but fails to elect continuation of coverage under USERRA, the Plan Sponsor will continue coverage for the first 30 days after Employee's departure from employment due to active military service. The Plan Sponsor will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled *Maximum Period of Coverage* (on the following page), then the Employee will be retroactively

reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

- ***Cost of USERRA Continuation Coverage:*** The Employee must pay the cost of coverage (herein premium). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan sponsor will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Sponsor will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.

- ***Maximum Period of Coverage:*** The maximum period of USERRA continuation coverage is the lesser of:

    - 24 months, or
    - the duration of Employee's active military service.

- ***Reinstatement of Coverage Following Active Duty:*** Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions. The Employee must return to employment:

    - on the first full business day following completion of military service for military leave of 30 days or less, or
    - within 14 days of completion of military service for military leave of 31-180 days, or
    - within 90 days of completion of military service for military leave of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period or preexisting condition exclusion can be imposed on a returning Employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

YOUR COST

MPC pays the full cost required to provide medical coverage, including prescription benefits, for you and your covered dependents per the appropriate collective bargaining agreement or board policy.

Domestic Partner Status

MPC cost of providing domestic partner benefits is considered taxable income by the IRS. When an employee enrolls a domestic partner or the partner's child in company-sponsored health care plan, the employee's contribution and the MPC's contribution for that coverage are the same as for a spouse and spouse's child. However, due to IRS regulations, these contributions for domestic partners are taxable income and will be added to the employee's pay as additional wages. This may be reported on the employee's annual Form W-2 and/or Form 1099 and increases the employee's taxable gross income for federal and state income taxes as well as for FICA (Social Security and Medicare) taxes withheld from paychecks. The amount of the additional taxable income depends upon the plan in which the employee is enrolled and the resulting level of coverage (employee/spouse, employee/child, family).

Description of Benefits

MEDICAL BENEFIT SUMMARY

Having the appropriate medical coverage is essential to you and your family's health and well being. This medical plan provides broad, comprehensive protection to cover a wide range of medical providers, services and supplies. Keep in mind that **if you or your dependents are enrolled in the medical plan:**

- You and any covered dependents will automatically receive prescription coverage.
- The plan has a *Pre-Authorization Program* and *Case Management Program* to ensure that you are receiving the appropriate medical care in the most effective setting possible and that the services are covered. See the *Utilization Management Program* section.

Preferred Provider Organization (PPO)

A PPO plan allows you to receive medical care and services from any physician or facility you choose. As a PPO plan participant, you do not need to select a primary care physician, nor do you need referrals for a specialist. There are two types of providers:

- ***In-Network Providers:*** Physicians and hospitals, which have agreed to become part of the network and provide care to members at a lower negotiated rate.
- ***Out-of-Network Providers:*** Any provider not affiliated with the network is out-of-network. For out-of-network providers, you are also responsible for all expenses that exceed the Usual, Reasonable and Customary (UCR) allowance (the range of fees usually charged by health care providers for the same service or supply in the same (or comparable) geographic area; for additional information about UCR, see *Usual, Customary and Reasonable (UCR)*.

Finding a Provider

Because physicians and hospitals frequently change their affiliations with networks and organizations, printed directories become quickly outdated. To ensure that the provider you are going to receive treatment from is currently in the network, **contact Delta Health Systems before** each visit or hospital stay. For contact information, see *Directory of Service Providers.*

When a network Provider Cannot be Used

In the following situations, when a network provider cannot be used, out-of-network provider services will be covered at the out-of-network benefit levels EXCEPT as follows:

- ***Emergency Care:*** If a covered person requires care for a medical emergency and must use the services of an out-of-network provider, any such expenses will be paid at Anthem Blue Cross network benefit levels (of the Usual, Customary and Reasonable (UCR) rate as defined on the next page) until the patient's condition has been stabilized to the point that he/she could be transferred to a network provider. In the case of an emergency non-Network Hospital admission, once the patient is stabilized and able to be transferred to a Network Hospital, benefits will cease if the transfer does not occur. However, the Plan reserves the right to determine benefits if the confinement is out of the local area of any Network Hospital or if necessary services are not available at a Network Hospital.
- ***No Choice of Provider:*** If, while receiving treatment in a covered network facility, a covered person receives ancillary services from an out-of-network provider — in a situation in which the patient has no control over provider selection (such as in the selection of an emergency room physician, an anesthesiologist or a provider for diagnostic services), such out-of-network services will be covered at the Anthem Blue Cross network benefit levels (of the Usual, Customary and Reasonable (UCR) rate as defined on the next page).
- ***Unavailable Services:*** If a covered person uses an out-of-network provider specialist because the necessary specialty is not represented in-network or is not within a **30-mile radius** of your residence for providers and a **30-mile radius** for hospitals, such out-of-network specialist care will be covered at the in-network benefit levels (of the usual and customary rate).
- ***Lab Referrals***: If a network provider submits a specimen to an out-of-network laboratory, such services will be covered at the in-network benefit levels (of the Usual, Customary and Reasonable (UCR) rate as defined on the next page). This exception will not apply if the covered person and/or the provider selected (or had the opportunity to select) a network provider and exercised the right to receive services from an out-of-network provider.

Important: In some rare instances, services may be rendered when a Network provider is not available or able to render the required services. In such instances, the Plan reserves the right to negotiate costs and determine the benefit level on a case-by-case basis. The Plan also reserves the right to supersede Plan benefits and/or to negotiate separate provider contracts and to direct care when deemed appropriate.

Usual, Customary and Reasonable (UCR)

A charge made by a provider that does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of health conditions comparable in severity and nature to the health condition being treated. The term area as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges.

With regard to charges made by a provider of service participating in the Plan's Network program, UCR will mean the provider's negotiated rate; however, it is not to exceed the actual charge or the Out-of-Network UCR allowance unless such lesser amount is not permitted under the terms of the Network agreement.

Medical Necessity: Determination of Covered Expenses

Approval of a claim is subject to the determination of the medical necessity of provided services. Medical necessity is a broadly accepted professional term meaning services were essential to treatment of the illness or injury. Any health care treatment, service or supply, in order to be medically necessary must be:

- ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury,
- the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition,
- furnished by a provider with appropriate training and experience, acting within the scope of his or her license,
- provided at the most appropriate level of care needed to treat the particular condition,
- consistent with symptoms or diagnosis and treatment of the condition, disease, ailment illness or injury,
- appropriate with regard to standards of good medical practice,
- not primarily for the conveniences of the patient, the physician or other Provider, and
- the most appropriate supply or level of services that can safely be provided to the patient. When applied to an inpatient, it means the patient's medical symptoms or condition require services or supplies which cannot be safely provided to the patient as an outpatient.

The Administrator will determine whether the above requirements have been met based on:

- published reports in authoritative medical and scientific literature,
- regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS),
- listings in the following compendia: *The American Hospital Formulary Service Drug Information* and *The United States Pharmacopoeia Dispensing Information*, and
- other authoritative medical resources to the extent the Plan Sponsor determines them to be necessary.

Your benefits are paid by taking the amount of covered expense for all medically necessary services, subtracting any applicable deductible and paying the remaining at the percentage payable, less any applicable copays, up to the benefit maximum. A covered expense is subject to the exclusions, conditions and limitations stated within this Summary Plan Description. Services and supplies must be ordered by a physician and be furnished by an eligible Provider and be medically necessary.

Expenses That Are Not Medically Necessary

The fact that a procedure or level of care is prescribed by a physician does not mean that it is a covered expense under the plan and shall not bind MPC in determining the liability under the plan. Services which are not reasonable and necessary shall include, but are not limited to, **procedures** that:

- are experimental, of unproven value or of questionable current usefulness,
- tend to be redundant when performed in combination with other procedures,
- are unlikely to provide a physician with additional clinical information when the procedures are used repeatedly,
- can be performed with equal efficiency at a lower level of care, or
- are primarily for the convenience of the insured, the insured's physician or another provider.

The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion.

UTILIZATION MANAGEMENT PROGRAM (UMP)

Unnecessary medical care and hospital stays, or stays that last longer than necessary, cause medical costs to increase. Sometimes, individuals are hospitalized for procedures that can be performed safely, effectively and more comfortably in an alternative setting, such as a hospital's outpatient department or physician's office. As a result, MPC has contracted with an independent organization to provide:

- **MANDATORY: Authorization** to approve medical necessity when you or your dependent requires certain care or services (as listed on the following page) or if you need to continue a stay beyond the period initially certified.

- **RECOMMENDED: Case Management** is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health care needs. Case management provides quality outcomes by gathering input and support from the patient, their support system such as family and friends, all care providers, vendors and other suppliers involved in the care and treatment to achieve agreed upon goals for the patient.

The name and phone number of the Utilization Management Program is shown on the employee's coverage identification card, as well as under **Directory of Service Providers**.

MANDATORY: Authorization

It is the employee's or covered person's responsibility to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an employee should contact the review organization to make certain that the facility or attending physician has initiated the necessary processes.

Additional information about when authorization is required, including timeframes and penalties for non-compliance is outlined on the following pages.

When calling for authorization, please have the following information ready:

- Employee's name, last four digits of the Social Security number, or assigned ID number,
- patient's name, date of birth, sex and contact telephone number,
- hospital's name, location and telephone number,
- date of admission,
- diagnosis and/or surgical procedure, if known, and
- date of surgery, if available.

Important: Authorization is **not a guarantee of coverage**; the *Utilization Management Program* is designed ONLY to determine whether or not a proposed setting and course of treatment is medically necessary and appropriate. Benefits under the plan will depend upon the person's eligibility for coverage and the plan's limitations and exclusions. Nothing in the *Utilization Management Program* will increase benefits to cover any confinement or service that is not medically necessary or that is otherwise not covered under the plan.

The Plan Sponsor has contracted with an independent organization to provide Authorization. See the name and phone number of the organization shown on the Employee's coverage identification card, or see the *Directory of Service Providers* at the beginning of this Summary Plan Description.

When Authorization Is Required

You are responsible for authorization in the following situations, unless there is an inability to obtain approval based on circumstances beyond your control, as outlined below the chart.

Important: If you have any questions as to whether a particular medical procedure is covered under current standards, **you should always verify benefits before incurring the expense**, even if the mandatory review program does not apply. See the *Directory of Service Providers* section for Utilization Management Program contact information.

Care or Services	Recommended Timeframe To Complete	Penalty for Non-Compliance
Authorization by Anthem Blue Cross		
Scheduled/NON-EMERGENCY Inpatient Hospital Stays Including inpatient for: ▪ Medical/Surgical Care ▪ Mental Health and/or Substance Abuse Care ▪ Skilled Nursing Facility ▪ Hospice Care For information about a maternity/inpatient stay, see *To Continue a Stay Beyond the Period Certified* below.	At least **3 business days** prior to the admission **or** before the patient is discharged.	Benefits may be delayed or denied
Non-Scheduled/EMERGENCY Inpatient Hospital Stays Including inpatient for: ▪ Medical/Surgical Care ▪ Mental Health and/or Substance Abuse Care ▪ Skilled Nursing Facility ▪ Hospice Care For information about a maternity/inpatient stay, see *To Continue a Stay Beyond the Period Certified* below.	Within **48 hours** of an admission	
To Continue a Stay Beyond the Period Certified **Maternity Stay:** When a maternity needs to be extended beyond 48/96 hours (depending on the type of birth), authorization will be required. See *Pregnancy and Maternity Care* under *Eligible Medical Expenses* for additional information.	**Before** the original timeframe expires	
Other Procedures/Care ▪ Home Health Care ▪ Home Injectables ▪ Hospice Care (Outpatient) ▪ Infusion Therapy ▪ Investigational Procedures ▪ PKU-Related Formulas or Special Food Products ▪ Potentially Cosmetic/Investigative Services ▪ Transplants ▪ Weight Loss Surgery for Morbid Obesity	**Prior to** care, treatment or admission	

Inability to Notify or Receive Authorization
The plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining Authorization impossible or where application of the authorization process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).

Delay Receiving Authorization
If a covered person does not receive the preauthorized services within 60 days of the authorization, a new authorization will be required.

Failure to Notify or Receive Authorization
In addition to the penalties listed in the chart under *When Authorization is Required* on the previous page, the following consequences will also be imposed if you do not receive authorization when required:

- expenses for treatment or hospital stays that are not considered medically necessary will not be covered, and
- any additional share of expenses which becomes the covered person's responsibility for failure to comply with these requirements will **not** be considered eligible medical expenses and thus will not apply to any deductibles, coinsurance or out-of-pocket maximums of the plan.

See the *Pre-Service Claims* section for more information, including information on appealing an adverse decision (i.e. a benefit reduction) under this program.

RECOMMENDED: Case Management Services
The Utilization Management Organization provides case management for catastrophically ill or injured Covered Persons who require extensive medical services and who have exceptional or complex needs. Case managers are responsible for evaluating and monitoring the efficiency, appropriateness and quality of all aspects of health care for Covered Persons who have been accepted into the case management program.

To achieve this objective, the case management program works in collaboration with the Covered Person's team of health care professionals to provide feedback, support and assistance during the utilization and case management process.

Once a Covered Person is identified for potential case management, the Covered Person is contacted for program enrollment. The case manager will introduce and describe the program. The Covered Person can ask questions and agree or decline to participate. If the Covered Person declines to participant, a case manager may work with the health care treatment team to monitor progress through the healthcare continuum.

Important: Case Management is voluntary. There are no reductions of benefits or penalties if the patient chooses not to participate. Also, each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

SCHEDULE OF MEDICAL BENEFITS

This chart below applies to those Employees (and their eligible and enrolled Dependents) who are enrolled in the medical plan. See *Eligibility and Effective Dates* section for more information.

Summary of Deductibles, Out-of-Pocket and Lifetime Maximums

The chart below shows what portion of expenses you will be responsible for, as well as how maximums are determined.

Type of Benefit	Member Responsibility	
	In-Network Providers	**Out-of-Network Providers**
Deductible (Calendar Year) The portion of covered eligible expenses you pay each year **before** the plan pays benefits. Covered expenses applied to your in-network deductible do not count toward your out-of-network deductible and vice versa. ▪ **Employee Only Coverage** ▪ **Family Maximum** Each member contributes toward the family deductible until it is satisfied. **Carry Over:** Any portion of the deductible that is met in the last three months of the calendar year will be carried over to help satisfy the deductible requirements for the next year.	$250 $250/person up to a maximum of $750/family	$500 $500/person up to a maximum of $1,500/family
Out-of-Pocket Maximum (Calendar Year) As added protection for you, the plan places a limit on how much you have to pay out of your own pocket for covered medical expenses each year. Once the limit is met, the plan pays 100% of the remaining covered expenses for that calendar year. Covered expenses applied to your in-network out-of-pocket maximum do not count toward your out-of-network out-of-pocket maximum and vice versa. ▪ **Employee Only Coverage** ▪ **Family Maximum** The following expenses do not accumulate toward the out-of-pocket maximum: ▪ expenses that are not covered under the plan, ▪ expenses which become the covered person's responsibility for failure to receive authorization, ▪ amounts applied or paid to satisfy any Deductible or Copay requirements, ▪ prescription drugs, or ▪ amounts over Usual, Customary and Reasonable (UCR).	$2,500 $2,500/person up to a maximum of $5,000/family	$3,500 $3,500/person up to a maximum of $7,000/family
Individual Lifetime Maximum	No lifetime maximum	

Medical Benefit Summary

This section outlines Eligible Medical Expenses covered by the medical plan. In reviewing this chart, keep in mind the following important terms:

- **Copay** (shown as a **dollar amount**): Refers to the amount **you pay**, at the time covered care or services are received.
- **Coinsurance** (shown as a **percentage**): Refers to the amount **you pay** (i.e., the amount you or your dependents will be billed for) after covered care or services are received.
- **Usual, Customary and Reasonable (UCR):** When you receive benefits from an out-of-network provider, benefits will be paid based on the location of the provider and the type of services received; see the Usual, Customary and Reasonable (UCR) section for additional information.

If you have any questions as to whether a particular medical procedure is covered under current standards, you should always check **before** incurring the expense, even if Authorization is not required. Delta Health Systems can provide you with detailed benefit information; contact information is available under the *Directory of Service Providers.*

This is a summary only. For a better understanding of the medical expenses listed in the chart, as well as definitions of other covered care and services, see **Eligible Medical Expenses** and **Medical Limitations and Exclusions,** as well as the **General Exclusions** sections for more information.

Note: All expenses are subject to the deductible unless it states the deductible is waived (i.e., Ded. Waived).

Eligible Medical Expenses	Member Responsibility	
	In-Network Providers	**Out-of-Network Providers** (Based on UCR)
Acupuncture Maximum of three visits/week; eight visits/diagnosis	$25 then 5%; Ded. Waived	$25 then 5%; Ded. Waived
Allergy Testing & Treatment Testing, Serum/Allergens and Injection, per visit	5%; Ded. Waived	30%; Ded. Waived
Ambulance	5%	5%
Ambulatory Surgical Center	5%	30%
Birthing Center	5%	30%
Blood	5%	30%
Cardiac Rehabilitation	5%	30%
Chemotherapy	5%	30%
Chiropractic Care, per visit	$25 then 5%; Ded. Waived	$25 then 30%; Ded. Waived
Diagnostic Lab & X-ray (Outpatient)	5%	30%
Dialysis	5%	30%
Durable Medical Equipment and Oxygen	5%	5%
Family Planning ▪ Office Visit	$25 then 5%; Ded. Waived	$25 then 30%; Ded. Waived
▪ Devices	5%	30%
▪ Elective abortions, tubal ligations and vasectomy	5%	30%
▪ Genetic testing (for high-risk during pregnancy)	5%	30%
▪ Reversal surgery	Not covered	Not covered
▪ Injections	5%	30%
▪ Infertility		
▪ Diagnostic	5%	30%
▪ Treatment	Not covered	Not covered

Medical Benefit Summary, continued

Note: All expenses are subject to the deductible unless it states the deductible is waived (i.e., Ded. Waived).

Eligible Medical Expenses	Member Responsibility	
	In-Network Providers	**Out-of-Network Providers**
Foot Care (Routine) Covered only when related to a metabolic or peripheral vascular disease.	5%	30%
Hearing Exams & Hearing Aids	Not covered	Not covered
Home Health Care Authorization Required Including IV therapy and PKU therapy $7500.00 maximum – combined with Hospice Care	5%	30%
Hospice Care Authorization Required Maximum stay of six months. $7500.00 maximum – combined with Home Health Care	5%	30%
Hospital Services & Supplies ▪ Inpatient Care Authorization Required ▪ Tier 1 ▪ Tier 2 ▪ Tier 3	*Based on Tier:* 0% 10% 20%	20%
▪ Emergency Room Use: Authorization Required ○ for an Accidental Injury or Medical Emergency	$100 (waived if admitted) then 5%; Ded. Waived	$100 (waived if admitted) then 5%; Ded. Waived
○ for a Non-Emergency	$100 then 5%	$100 then 30%
▪ Outpatient Surgical Services & Supplies	5%	30%
▪ Urgent Care (Stand-Alone Facility)	$25.00 then 5% Ded. Waived	$25 then 30%; Ded. Waived
Infusion Therapy Authorization Required	$25 then 5%; Ded. Waived	$25 then 30%; Ded. Waived
Massage Therapy	Not covered	Not covered
Maternity Care	5%	30%
Medication Management	$25 then 5%; Ded. Waived	$25 then 30%; Ded. Waived
Mental Health and Substance Abuse Care ▪ Home /Office Visit or Day Treatment	$25 then 5%; Ded. Waived	$25 then 30%; Ded. Waived
▪ Inpatient/Residential Care (facility and professional services) Authorization Required ▪ Tier 1 ▪ Tier 2 ▪ Tier 3	*Based on Tier:* 0% 10% 20%	20%
▪ Testing	5%	30%
Occupational Therapy Only when provided in conjunction with Home Health Care.	5%	30%
Physical Therapy When prescribed by a physician and provided by a registered physical therapist.	$25 then 5%; Ded. Waived	$25 then 30%; Ded. Waived

Medical Benefit Summary, continued

Note: All expenses are subject to the deductible unless it states the deductible is waived (i.e., Ded. Waived).

Eligible Medical Expenses	Member Responsibility	
	In-Network Providers	**Out-of-Network Providers**
Physician Services ▪ Emergency Room	5%; Ded. Waived	5%: Ded. Waived
▪ Inpatient Care (facility and professional services)	5%	30%
▪ Office or Home Visit	$25 then 5%; Ded. Waived	$25 then 30%; Ded. Waived
▪ Other Services	5%	30%
PKU-Related Formulas or Special Food Products Authorization Required	5%	30%
Pre-Admission Testing	5%	30%
Preventive Care	$0; Ded. Waived	30%
Prosthetic Devices	5%	5%
Pulmonary Therapy	5%	30%
Radiation Therapy	5%	30%
Respiratory Therapy	5%	30%
Second (& 3rd) Surgical Opinion	$25 then 5%; Ded. Waived	$25 then 30%; Ded. Waived
Skilled Nursing Facility / Rehabilitation Center Authorization Required	5%	30%
Sleep Disorders (Testing) *Note: Any related equipment, see Durable Medical Equipment*	5%	30%
Speech Therapy Coverage only available after surgery, injury or non-congenital organic disease.	$25 then 5%; Ded. Waived	$25 then 30%; Ded. Waived
Transplants Authorization Required	5%	30%

ELIGIBLE MEDICAL EXPENSES

This section must be read in conjunction with the *Summary of Medical Benefits* to understand how plan benefits are determined (application of deductible requirements and benefit sharing percentages, etc.). **Important:** If the benefit in the *Summary of Medical Benefits* section shows not covered, then the benefit information in this section is not applicable. All medical care must be received from or ordered by a Provider.

To be **eligible** (i.e., covered) under the medical plan, expenses related to services, supplies and/or care **must be**:

- medically necessary for the care and treatment of a **covered:** sickness, Accidental Injury, pregnancy or other health care condition,
- the Usual, Customary and Reasonable charges for the items specifically listed in this Summary Plan Description,
- incurred while the person is covered by this plan, **and**
- approved by a physician or other appropriate Provider.

Keep in mind:

- only those medical services, supplies and conditions which are covered by the plan are outlined in this section, and
- an individual who meets the eligibility requirements as contained herein (e.g., a covered employee, a covered dependent, a Qualified Beneficiary (COBRA), etc.) is considered a covered person.

For benefit purposes, medical expenses will be deemed to be incurred on the:

- date a purchase is contracted, or
- actual date a service is rendered.

Important: Eligible medical expenses are subject to the definitions, limitations and exclusions and all other provisions of the plan; specific guidelines are outlined in this section, as well as the *Summary of Medical Benefits*, *Medical Limitations and Exclusions* and *General Exclusions.*

Acupuncture / Acupressure: Needle puncture or application of pressure at specific points, whether used to cure disease, to relieve pain or as a form of anesthesia for surgery.

Accident-Related Injury: Any accidental bodily injury that is caused by external forces under unexpected circumstances and that is not excluded due to being employment-related (see **General Exclusions** section), subject to the following conditions:

- Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

- The deductible will not be applied to the first $500 of covered services as the result of an accidental injury if expenses are incurred within 90 days of the accident.

- Expenses eligible for the benefit are limited to charges for Hospital services, Physician services, diagnostic lab and X-ray services and professional ambulance services. Other expenses will be covered in the same manner as a Sickness and will be based on the types of expenses incurred.

- Any Copay that would apply to a non-accident-related expense will also apply before the accident benefit is available. For example, if treatment involves a visit to an Urgent Care Facility, that Copay will apply before the accident-related expense benefit is determined.

Alcoholism: See *Substance Abuse Care*

Allergy Testing & Treatment: Allergy testing and treatment, including allergy injections.

Ambulance: Professional ground or air ambulance service when used to transport the Covered Person from the place where he/she is injured or stricken by a Sickness to the nearest Hospital where treatment can be given.

Ambulatory Surgical Center: Services and supplies provided by an *Ambulatory Surgical Center* in connection with a covered Outpatient surgery. An Ambulatory Surgical Center is any public or private establishment that:

- complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located,
- has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures,
- provides continuous Physician services and registered professional nursing services whenever a patient is in the facility, and
- does not provide services or other accommodations for patients to stay overnight.

Anesthesia: Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

Birthing Center: Services and supplies provided by a *Birthing Center* in connection with a covered Pregnancy. A birthing center is a special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility that:

- is in compliance with licensing and other legal requirements in the jurisdiction where it is located,
- is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients,
- has organized facilities for birth services on its premises,
- provides birth services by or under the direction of a Physician specializing in obstetrics and gynecology,
- has 24-hour-a-day registered nursing services, and
- maintains daily clinical records.

Blood: Blood and blood derivatives (if not replaced by or for the patient), including blood processing and administration services.

Cardiac Rehabilitation: A monitored exercise program directed at restoring both physiological and psychological well-being to individuals with heart disease. Services rendered must be under the direction of a Physician and provided at a medical facility. *Note: Maintenance care will not be covered.*

Chemical Dependency: See *Substance Abuse Care*

Chemotherapy: Professional services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

Chiropractic Care: Musculoskeletal manipulation and modalities (hot & cold packs, etc.) provided by a chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.

Contraceptives: Contraceptive supplies and related Physician services provided in connection with the fitting, administration or placement of contraceptive devices, injectables, implants, etc., (e.g., Depo-Provera, intrauterine devices (IUDs), diaphragms, and Norplant). See also “Prescription Drugs”. *Note: Contraceptives that can be obtained without a Physician's written prescription (e.g., condoms, foams, jellies, etc.) or contraceptives that do not require the services of a Physician are not covered.*

Convalescent Hospital: See *Skilled Nursing Facility*

Cosmetic & Reconstructive Surgery (Authorization Required)**:** Is only covered under the following circumstances:

- services necessitated by an Accidental Injury,
- treatment necessary to repair damage due to a medical complication resulting from a surgical procedure,
- coverage required by the *Women's Health and Cancer Rights Act* (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient, and
- treatment necessary to correct a congenital abnormality (birth defect).

Covered Provider: An individual who is:

- licensed to perform certain health care services that are covered hereunder and who is acting within the scope of his/her license, or
- in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association, and a/an:

  - Acupuncturist
  - Audiologist*
  - Certified Registered Nurse Anesthetist (CRNA)
  - Chiropractor (DC)
  - Dentist (DDS or DMD)
  - Dispensing Optician
  - Licensed Clinical Psychologist (PhD or EdD)
  - Licensed Clinical Social Worker (LCSW)*
  - Licensed Practical Nurse (LPN)
  - Licensed Vocational Nurse (LVN)
  - Marriage Family and Child Counselor (MFCC)
  - Nurse Practitioner
  - Occupational Therapist (OTR)**
  - Optometrist (OD)
  - Physical Therapist (PT or RPT)*
  - Physician - see definition of "Physician"
  - Physician Assistant (PA)
  - Podiatrist or Chiropodist (DPM, DSP or DSC)
  - Psychiatrist (MD)
  - Registered Nurse (RN)
  - Respiratory Therapist
  - Speech Pathologist*

** Services by these types of providers require a referral by a physician.*
*** Services of an Occupational Therapist are covered only when provided in conjunction with home health care.*

A "Covered Provider" will also include the following when appropriately-licensed and providing services that are covered hereunder:

- facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, etc.,
- licensed Outpatient mental health facilities,
- freestanding public health facilities,
- hemodialysis and Outpatient clinics under the direction of a Physician (MD),
- enuresis control centers,
- prosthetists and prosthetist-orthotists,
- portable X-ray companies,
- independent laboratories and lab technicians,
- diagnostic imaging facilities,
- blood banks,
- speech and hearing centers, and
- ambulance companies.

A Covered Provider does not include:

- a Covered Person treating himself or any relative or person who resides in the Covered Person's household; see "Relative or Resident Care" in the list of **General Exclusions**, or
- any Physician, nurse or other provider who is an employee of a Hospital or other Covered Provider facility and who is paid by the facility for his/her services.

Dental Services, Accident Only: Dental services when all of the following are true:

- treatment is necessary because of Accidental Injury,
- dental services are received from a Doctor of Dental Surgery (DDS) or doctor of Medical Dentistry (DMD), and
- dental services for treatment to repair the damage must be started within six months of the accident.

Note: Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an Accidental Injury and repair of such damage is not covered.

Diagnostic Lab & X-ray, Outpatient: Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

Dialysis: Services and supplies, including the training of a person to assist the patient with home dialysis, when provided by a Hospital, freestanding dialysis center or other appropriate Covered Provider.

Durable Medical Equipment: Rental of durable medical or surgical equipment (but not to exceed the fair market purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury.

"Durable medical equipment" includes such items as crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment, etc., that:

- can withstand repeated use,
- are primarily and customarily used to serve a medical purpose,
- generally are not useful to a person in the absence of Sickness or Accidental Injury, and
- are appropriate for use in the home.

Note: Coverage is limited to the least expensive item that is adequate for the patient's needs. Duplicate equipment or excess charges for deluxe equipment or devices will not be covered.

Emergency (Authorization Required for an emergency only if it results in an admission/ inpatient hospital stay)**:** An emergency is an accidental injury or the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions, a medical emergency also includes one in which:

- there is inadequate time to effect a safe transfer to another hospital before delivery, or
- transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services: Emergency services for a medical condition include but are not limited to:

- a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition,
- further medical examination and treatment as may be necessary to stabilize the individual.

During a medical emergency, medical treatment must be provided:

- such that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to delivery of a child (including the placenta), that the woman has delivered (including the placenta), and
- until the patient is stabilized. Stabilization includes the movement or discharge of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who:
    - has been declared dead, or
    - leaves the facility without the permission of any such person.

Foot Care (Non-Routine): Limited to only the removal of nail roots, other podiatry surgeries or foot care services necessary due to a metabolic or peripheral vascular disease.

Home Health Care (Authorization Required)**:** Services and supplies that are furnished to a Covered Person in accordance with a written home health care plan. The home health care plan must be established by the Covered Person's attending Physician and must be monitored by the Physician during the period of home health care.

Home health care services and/or supplies must be provided through a Home Health Care Agency. Covered home health care services and supplies include:

- services of a registered nurse (RN) or a licensed vocational nurse (LVN),
- services of a certified nursing assistant,
- services of a home health aide,
- services of a physical, occupational or speech therapist, and
- medical supplies and materials.

Services of a Private Duty Nurse are not covered by the Plan.

Home Health Care Agency: An agency or organization that:

- is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services,
- has policies established by a professional group associated with the agency or organization that includes at least one registered nurse (RN) to govern the services provided,
- provides for full-time supervision of its services by a Physician or by a registered nurse,
- maintains a complete medical record on each patient, and
- has a full-time administrator.

In rural areas where there are no agencies that meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospice Care (Authorization Required)**:** Care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less) who has been admitted to a formal program of Hospice care. Hospice care includes care in either the patient's home or a facility or both and includes:

- services of a registered nurse (RN) or licensed vocational nurse (LVN),
- services of a certified nursing assistant, and
- materials and supplies.

Note: See Mental Health Care *for bereavement counseling coverage.*

Hospice or **Hospice Agency**: An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital (Authorization Required)**:** Hospital services and supplies that are provided on an Outpatient basis or on an Inpatient care, including daily room and board and ancillary services and supplies. Inpatient room and board is limited to a semi-private room or necessary use of an Intensive Care Unit. However, a private room will be allowed if isolation is required or if a private room is requested by the attending Physician and required for medical reasons. A Hospital is an institution that is:

- providing Inpatient care and treatment through medical, diagnostic and major surgical facilities on its premises, under the supervision of a staff of doctors and with a 24-hour–a-day nursing service, or
- accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.

A "Hospital" does not include a nursing home or an institution or part of an institution used mainly as a facility for convalescence, nursing, rest of the aged or the care of drug addicts or alcoholics, except as provided for the rehabilitation of alcoholism or drug addiction.

Infusion Therapy (Authorization Required)**:** Professional services of an appropriate Covered Provider for the intravenous or aerosol administration of prescription drugs or other prepared or compounded substances. Infusion therapy may be administered in a Covered Person's home, Physician's office or at a Covered Provider facility.

Infusion therapy supplies including injectable prescription drugs or other substances that are approved by the Food and Drug Administration, and durable medical equipment necessary for infusion therapy.

Injectables (Authorization Required)**:** Injectables that are not available through the prescription drug program and professional services for their administration if they cannot be self-administered.

Inpatient (Authorization Required)**:** A person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) that is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit (Authorization Required)**:** A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, that provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and that is separated from the rest of the Hospital's facilities.

Medical Supplies: Medical supplies such as surgical dressings, catheters, colostomy bags and related supplies. Syringes and testing materials for diabetes.

Medicines: Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit, or as part of a home health care or hospice care program.

Mental Health Care (Authorization Required for Inpatient and Residential Treatment)**:** Inpatient, day treatment, residential, testing and outpatient home and office treatment of mental health conditions. Outpatient treatment will also include bereavement counseling services following the death of a family member. For Plan purposes, "mental health conditions" include schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, manic-depressive illness), anxiety disorders, somatoform disorders, personality disorders and disorders of infancy, childhood and adolescence.

A mental health condition or covered mental health care will **not** include:

- learning and behavior disorders including attention deficit disorder,
- hyperkinetic syndrome,
- autism,
- mental retardation,
- hypnotherapy,
- marriage and family counseling,
- sex counseling or sex therapy, or
- vocational testing or training.

Mental Health Facility: An institution that is licensed by the state and accredited by the Joint Commission on Accreditation of Healthcare Organizations or an institution that is a licensed Community Mental Health Agency. A Mental Health Facility must be able to provide acute medical care to its patients or maintain a contract or agreement with a Hospital in the area to provide acute medical care to a patient should a Medical Emergency arise.

Newborn Care: Medically Necessary services and supplies, as listed herein, for a covered newborn who is sick or injured. See *Pregnancy Care* for routine well-newborn expenses.

Occupational Therapy: Only covered when provided in conjunction with home health care; services must be rendered by a Physician or by an occupational therapist (upon written orders of a Physician).

Outpatient: Services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hospital facility.

Outpatient Surgical Center: A facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

Oxygen: See *Durable Medical Equipment*

Physical Therapy: Treatment, under the direction of a Doctor of Medicine and provided by a registered physical therapist, or licensed doctor of podiatric medicine, utilizing physical agents such as ultrasound, heat and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Physician Services: Medical and surgical treatment by a Physician (MD or DO) who is licensed to practice medicine or osteopathy where the care is provided, including office, home or Hospital visits, clinic care and consultations. See *Second (& 3rd) Surgical Opinion* for requirements applicable to surgery opinion consultations. Also see *Covered Providers*.

PKU-Related Formulas or Special Food Products (Authorization Required)**:** PKU is the abbreviation for a metabolic disorder called phenylketonure in which a portion of protein, called phenylalanine, is not processed correctly. Benefits are provided for formulas and Special Food Products that are medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).

Pregnancy Care: Pregnancy-related expenses include the following, but may include other services that are deemed to be Medically Necessary by the patient's attending Physician:

- pre-natal visits and routine pre-natal and post-partum care,
- expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of pregnancy,
- genetic testing or counseling when deemed Medically Necessary by a Physician, and

- newborn Hospital and pediatric services, including newborn circumcision, provided during the mother's confinement for delivery. This will not apply, however, if the newborn has a medical problem, is a Covered Person, and the charges are covered as the newborn's own claim.

In compliance with the *Newborns' and Mothers' Health Protection Act of 1996*, the plan also provides that:

- hospital stays will be covered for at least 48 hours following a normal vaginal delivery, or at least 96 hours following a Cesarean section,
- the attending physician does not need to obtain authorization from the plan to provide the mother and newborn with this length of hospital stay, and
- shorter hospital stays are permitted if the attending health care provider, in consultation with the mother, determines that this is the best course of action.

Authorization is Required when a maternity stay needs to be extended beyond 48/96 hours (depending on the type of birth).

Pregnancy coverage will not include:

- Lamaze and other charges for education related to pre-natal care and birthing procedures,
- adoption expenses,
- planned homebirths or any expenses related to complications resulting for the mother and/or child from a planned homebirth delivery, or
- expenses of a surrogate mother who is not a Covered Person.

Prescription Drugs: Drugs and medicines that are dispensed and administered to a Covered Person during an Inpatient confinement or during a Physician's office visit. Also see the **Prescription Drug Benefit** section.

Preventive Care: The preventive services listed below are a ***summary*** of the types of covered services that are provided without your having to pay a copay or coinsurance or meet your deductible if you use an **in-network provider**. There are three government clearinghouses that publish recommendations and guidelines for preventive care and require plans to provide coverage for:

- Evidence-based items or services rated A or B: United States Preventive Services Task Force.

- Immunizations for routine use in children, adolescents, and adults: Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

- Preventive care and screenings for women, infants, children, and adolescents: Health Resources and Services Administration.

These benefits are subject to change periodically; the most up-to-date information is available online; see the website address listed under *Directory of Service Providers*.

Keep in mind:

- Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.

- If you have questions about whether these new provisions apply to your plan, contact Contract Administrator; see the *Directory of Service Providers* for the telephone number.

- To know which covered preventive services are right for you—based on your age, gender, and health status—ask your health care provider.

Summary of Preventive Care Benefits

- ***Well-Baby Exams (Birth up to 2 years):*** Frequency based on pediatrician's recommendations. At the well-baby exam, you may get advice on your child's safety, health, healthy eating and development. At these exams, your baby may receive certain screenings and vaccinations.

- ***Well-Child Exams (2 up to 10 years):*** One visit each plan year. At the well-child exam, you may get advice on how to keep your child safe, how to prevent injuries, good health, healthy eating and development. At these exams, your child may receive certain screenings and vaccines.

- ***Well-Child Exams (10 up to 18 years):*** One visit each plan year. At the well-child exam, your doctor may discuss with you health and wellness issues, which may include healthy eating, exercise, healthy weight, how to prevent injuries, avoiding tobacco, alcohol and drugs, sexual behavior, mental health and secondhand smoke. At these exams, your child may receive certain screenings and vaccines.

- ***Well-Woman Exam (18 years and older):*** One visit each plan year. At the well-woman exam, the doctor may discuss with you health and wellness issues, which may include healthy eating, exercise, family planning for ages 19-39 and folic acid for women who are of the age to get pregnant, how to prevent injuries, misuse of drugs and alcohol, how to stop using tobacco, secondhand smoke, sexual behavior and mental health. At this visit, you may receive certain screenings and vaccines. Pregnant women may undergo additional screening tests.

- ***Well-Man Exam (18 years and older):*** One visit each plan year. At the well-man exam, the doctor may discuss with you health and wellness issues, which may include healthy eating, exercise, family planning for ages 19-39, how to prevent injuries, misuse of drugs and alcohol, how to stop using tobacco, secondhand smoke, sexual behavior and mental health. At this visit, you may receive certain screenings and vaccines.

Prosthetics: Includes coverage for:

- Initial purchase of an artificial limb, eye or other prosthetic appliance required to replace or perform the function of a natural limb, eye or other body part. To comply with the Women's Health and Cancer Rights Act, coverage includes post-mastectomy breast prostheses.
- Necessary repair or adjustment of a prosthetic.
- Replacement of a prosthetic when necessary due to a prescription change or long term wear and deterioration.

Prosthetics do not include:

- penile implants unless required as a result of irreversible vascular or neurologic disease that prevents normal male sexual function,
- any type of communicator, voice enhancement, voice prosthesis or any other language assistive device,
- external and internal power enhancements or power controls for prosthetic limbs and terminal devices, or
- myoelectric prostheses and peripheral nerve stimulators.

Radiation Therapy: Radium and radioactive isotope therapy.

Rehabilitation Center: A facility that is designed to provide therapeutic and restorative services to sick or injured persons and that:

- carries out its stated purpose under all relevant state and local laws,
- is accredited for its stated purpose by either the JCAHO or the Commission on Accreditation for Rehabilitation Facilities, or
- is approved for its stated purpose by Medicare.

Also see *Skilled Nursing Facility* or *Rehabilitation Center*

Respiratory Therapy: Professional services of a licensed respiratory or inhalation therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

Second (& 3rd) Surgical Opinion: A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be a Network provider and qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery. A third opinion consultation if the second opinion does not concur with the first Physician's recommendation. This third Physician must be a Network provider and qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

Semi-Private Room Charge: The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges. If the facility only provides private room accommodations, this provision does not apply.

Sickness: Bodily illness or disease (including mental health conditions or chemical dependencies), congenital abnormalities, birth defects and premature birth. A condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

Skilled Nursing Facility or Rehabilitation Center (Authorization Required)**:** Inpatient care in Skilled Nursing Facility or Rehabilitation Center, but only when the admission to the facility or center is prescribed by a Physician for a condition requiring treatment by a Physician. Inpatient room and board is limited to a semi-private room unless a private room is medically required. Transfer from a hospital to a skilled nursing facility must be immediate following a covered hospital stay. In addition, the patient must remain under the supervision of the physician treating the illness or injury for which the patient was confined. *Note: Benefits are not available for custodial care or for care of chronic brain syndrome, mental retardation, senile deterioration, except for Alzheimer's disease.*

Skilled Nursing Facility: An institution that:

- is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations,
- is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day for convalescing persons,
- is under the full-time supervision of a Physician or a registered nurse,
- admits patients only upon the recommendation of a Physician, maintains complete medical records, and has available at all times the services of a Physician,
- has established methods and procedures for the dispensing and administering of drugs,
- has an effective utilization review plan,
- is approved and licensed by Medicare,
- has a written transfer agreement in effect with one or more Hospitals, and
- is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

Speech Therapy: Services by a qualified speech therapist, but **only** when provided after surgery, injury or non-congenital organic disease. *Note: Speech therapy performed for any functional nervous disorder, mental or emotional disorder, autism, learning disability or any similar condition is not covered.*

Sterilization Procedures: A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female). *Note: Reconstruction (reversal) of a prior elective sterilization procedure is not covered.*

Substance Abuse Care (Authorization Required for inpatient and residential treatment)**:** Inpatient, day treatment, residential, testing and outpatient home and office treatment of substance abuse and addiction. For Plan purposes, "substance abuse and addiction" is abuse of and physical and/or psychological dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree.

Substance Abuse Facility: A facility that:

- is licensed by the state to treat alcoholism or drug addiction and provides treatment by or under a medical doctor and maintains medical records for each patient, or
- is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

A Substance Abuse Facility must be able to provide acute medical care to its patients or maintain a contract or agreement with a hospital in the area to provide acute medical care to a patient should a Medical Emergency arise.

Tiered Hospital Network: Hospitals that are within the network are grouped into 1 of 3 different tiers based on the cost or efficiency of care that they provide. Tier I network hospitals have a lower co-insurance than Tier II hospitals and Tier II hospitals have a lower co-insurance than Tier III hospitals.

Transplants (Authorization Required)**:** Eligible Expenses for a vital human organ or tissue transplant that is not experimental or investigational, subject to the following conditions:

- transplants are limited to only cornea, kidney, skin, heart, lung, liver, pancreas and bone marrow,
- when only the transplant recipient is a Covered Person, benefits will be provided for Eligible Expenses of the recipient and expenses of the donor to the extent that benefits to the donor are not provided under any other form of coverage (i.e., this Plan will be secondary to the donor's plan). Benefits paid will be applied to reduce benefit maximums as though all expenses were incurred by the Covered Person recipient,
- if the donor is covered hereunder but the recipient is not, the Plan will provide benefits if no benefits are available through the recipient's plan. If coverage does exist through the recipient's plan, this Plan will provide secondary coverage, and
- when the transplant recipient and the donor are both Covered Persons, benefits will be provided separately for each in accordance with his/her respective Eligible Expense.

The Plan reserves the right to determine if benefits will be made available for tissue obtained from a cadaver or tissue bank or charges for services or supplies or a surgeon or any facility used to remove, store or transfer such tissue. The Plan also reserves the right to provide a benefit for transportation costs for donor and/or recipient if it is determined that such coverage would be in the best interest of the individual and is the most cost effective for the Plan.

The following expenses **are not covered by the plan**:

- expenses incurred by a covered person/recipient and his/her companion for travel, lodging or food expenses,
- search for donors,
- pre-surgical and surgical hospital expenses incurred by a donor,
- transportation, accommodations or other expenses incurred by a donor,
- procedures for covered persons acting as a donor, or
- recipients who are not a covered person.

Urgent Care Facility: A facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

- a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times, and
- X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a stand-alone clinic or one that is operated in conjunction with (or that is part of) a regular Hospital; benefits vary depending on the type of facility in which care is rendered.

MEDICAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for the following expenses (see *General Exclusions* for other limitations on benefits):

Air Purification Units, Etc.: Air conditioners, air-purification units, humidifiers and electric heating units.

Biofeedback: Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

Complications of Non-Covered Treatment: Care, services or treatments that are required to treat complications resulting from a treatment or surgery that is not or would not be covered under the terms of the Plan, unless expressly stated otherwise.

Cosmetic & Reconstructive Surgery, Etc.: Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except for:

- services necessitated by an Accidental Injury,
- treatment necessary to repair damage due to a medical complication resulting from a surgical procedure,
- coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient, and
- treatment necessary to correct a congenital abnormality (birth defect).

Examples of surgeries that are considered cosmetic and **not** covered include, but are not limited to:

- surgical excision of any sagging skin on any part of the body,
- services in connection with the enlargement, reduction or change in appearance of the body unless deemed Medically Necessary or expressly covered,
- services in connection with chemical face peels or abrasion of the skin, or
- services or treatment to alter physical characteristics to those of the opposite sex.

Custodial & Maintenance Care: Care or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training. Any type of maintenance care which is not reasonably expected to improve the patient's condition, except as may be included as part of a formal Hospice care program. Custodial care is not covered when furnished primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self care and/or supervisory care by a Physician) or care furnished to a person who is mentally or physically disabled, and:

- who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing care; or
- when, despite medical, surgical or psychiatric treatment, there is no reasonable likelihood that the disability will be so reduced.

Dental Care: Dental care (braces and other orthodontic services or supplies) except as described under “Dental Services – Accident Only” in the list of **Eligible Medical Expenses.** Also excluded are dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, except as specifically stated under Treatment to Natural Teeth. Cosmetic dental surgery or other services for beautification.

Diagnostic Hospital Admissions: Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

Ecological or Environmental Medicine: Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin that are not specifically approved by the FDA as effective for treatment.

Educational or Vocational Testing or Training: Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation. Training of a Covered Person for the development of skills needed to cope with an Accidental Injury or Sickness, except as may be expressly included.

Exercise Equipment / Health Clubs: Exercising equipment, vibratory equipment, swimming or therapy pools, as well as enrollment in health, athletic or similar clubs.

Eye Care, Routine: Optometric services, eye exercises, including orthoptics, routine eye exams and routine eye refractions. Eye surgery solely for the purpose of correcting refractive defects of the eye such as near-sightedness (myopia) and astigmatism. Eyeglasses or contact lenses, except as specifically required as a result of a medical condition; other than those listed in this section.

Foot Care, Routine: Routine and non-surgical foot care services and supplies including, but not limited to:

- trimming or treatment of toenails,
- foot massage,
- treatment of corns, calluses, metatarsalgia or bunions, and
- treatment of weak, strained, flat, unstable or unbalanced feet.

This exclusion does not apply to Medically Necessary treatment of the feet (e.g., the removal of nail roots, other podiatry surgeries, or foot care services necessary due to a metabolic or peripheral-vascular disease).

Genetic Counseling or Testing: Counseling or testing concerning inherited (genetic) disorders. However, this limitation does not apply when such services are determined by a Physician to be Medically Necessary during the course of a Pregnancy that is covered by the Plan.

Growth Hormones / Growth Hormone Therapy

Hearing Aids, Hearing Exams or Tests

Hair Restoration: Replacement of nonproductive hair follicles with productive follicles from another area of the scalp or body for treatment of alopecia (baldness), or any other surgeries, treatments, drugs, services or supplies relating to baldness or hair loss.

Holistic, Homeopathic or Naturopathic Medicine: Services, supplies, drugs or accommodations provided in connection with holistic, homeopathic or naturopathic treatment.

Hypnotherapy: Treatment by hypnotism.

Impregnation: Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

Infertility Treatment: Studies, procedures, drugs or supplies to correct infertility or to restore or enhance fertility; including but not limited to artificial insemination and in-vitro fertilization.

Learning & Behavioral Disorders, Etc.: Testing or treatment for learning or behavioral disorders including attention deficit disorder (ADD), attention deficit hyperactive disorder (ADHD), mental retardation, or autism. Treatment of chronic brain syndrome or senile deterioration, except for Alzheimer's disease.

Maintenance Care: See *Custodial & Maintenance Care*

Massage Therapy: The manipulation of superficial layers of muscle and connective tissue. Massages, massage therapy, Rolfing (holistic tissue manipulation and movement), acupressure and/or aromatherapy are not covered.

Non-Prescription Drugs: Drugs for use outside of a hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription - except as may be included in the prescription Plan. Drugs for which there is a non-prescription equivalent available.

Not Medically Necessary / Not Physician Prescribed: Any services or supplies that are:

- not Medically Necessary, and
- not incurred on the advice of a Physician - unless expressly included herein.

Inpatient room and board when hospitalization is for services that could have been performed safely on an Outpatient basis including, but not limited to: preliminary diagnostic tests, physical therapy, medical observation, treatment of chronic pain or convalescent or rest cure.

Nursing Services, Private Duty: Private duty or special nursing services.

Orthognathic Surgery: Surgery to correct a receding or protruding jaw.

Orthotics: Orthopedic (non-dental) braces, casts, splints, trusses and other orthotics even if prescribed by a Physician or custom made.

Orthopedic Shoes: Except when joined to braces or shoe inserts.

Personal Comfort or Convenience Items: Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to:

- air conditioners, air purifiers, or vacuum cleaners,
- motorized transportation equipment, escalators, elevators, ramps,
- waterbeds or non-hospital adjustable beds,
- hypoallergenic mattresses, pillows, blankets or mattress covers,
- cervical pillows,
- swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs,
- home blood pressure kits,
- personal computers and related equipment, televisions, telephones, or other similar items or equipment,
- food liquidizers, or
- structural changes to homes or autos.

Pregnancy Coverage: The following services are not covered during a pregnancy/birth:

- Lamaze and other charges for education related to pre-natal care and birthing procedures,
- adoption expenses,
- planned homebirths or any expenses related to complications for the mother and/or child resulting from a planned homebirth delivery, or
- expenses of a surrogate mother who is not a Covered Person.

Preventive or Routine Care: Routine exams, physicals or anything **not ordered** by a Physician or care that is not Medically Necessary for treatment of Sickness, Accidental Injury or Pregnancy.

Self-Inflicted Injury Services: Services rendered to a Covered Person as a result to self-inflicted injury is covered up to the Specific Deductible set with the Reinsurance Carrier at the time of service.

Self-Procured Services: Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, that are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses**.

Sex-Related Disorders: Transsexualism, gender dysphoria, sexual reassignment or change, or other sexual dysfunctions or inadequacies. Excluded services and supplies include, but are not limited to: medications, implants, hormone therapy, surgery and other medical treatment.

TMJ / Jaw Joint Treatment: Services or supplies provided in connection with a diagnosis of temporomandibular joint dysfunction syndrome (TMJ) or rendered in connection with any TMJ treatment program or any services in connection with TMJ splinting or surgery except for necessary medical and/or surgical and arthroscopic treatment.

Vaccinations: Immunizations or vaccinations other than those included within the “Preventive Care” or as needed in connection with an accidental injury (i.e., tetanus or rabies).

Vision Care: There is no coverage for:

- eye examinations for the purpose of prescribing corrective lenses,
- vision supplies (eyeglasses or contact lenses, etc.) or their fitting, replacement, repair or adjustment, or
- orthoptics, vision therapy, vision perception training, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy or laser surgery.

This exclusion will not apply to: (1) services necessitated by a Sickness or Accidental Injury, or (2) the initial purchase of glasses or contact lenses following cataract surgery or keratoconus surgery.

Vitamins or Dietary Supplements, Etc.: Prescription or non-prescription vitamins. Dietary or nutritional supplements or any other form of special food product, regardless if such supplement or food is prescribed by a Physician, unless Medically Necessary and dispensed through infusion therapy. Services or supplies rendered by a dietary counselor or nutritionalist or services or supplies rendered for dietary planning or nutrition.
Vocational Testing or Training: Vocational testing, evaluation, counseling or training.

Weekend Admissions: Hospital expenses incurred on a weekend that coincides with admission to a Hospital between 12:00 (noon) on Friday and 12:00 (noon) on Sunday unless:

- the admission occurs one day prior to a scheduled surgery,
- the Covered Person is admitted on an emergency basis, or
- the admission is for Pregnancy delivery.

Weight Control, Etc.: Weight loss programs of any kind, whether or not prescribed by a Physician, or any other services, surgery or supplies rendered in connection with a diagnosis of obesity. This exclusion will not apply to surgical treatment of obesity if:

- surgical treatment of obesity is necessary to treat another life-threatening condition involving obesity, and
- It has been documented that non-surgical treatments of the obesity have failed.

Wigs or Wig Maintenance: See *Hair Restoration*

PRESCRIPTION DRUG BENEFITS

When you enroll in the medical plan, you automatically receive prescription coverage. Prescription benefit coverage is only available at participating Express Script retail pharmacy or through the mail-order pharmacy, as described below:

Type of Prescription	Retail Pharmacy 30-Day Supply	Mail Order Pharmacy 90-Day Supply
Retail Feature (30-day supply)		
▪ Formulary Prescriptions		
- Generic	$5	$10
- Brand-Name	$20	$40
▪ Non-Formulary Prescription	$35	$70

Mail Order

For new mail service prescriptions:

- If you need to start your medication right away, have your physician complete two prescriptions.
- Fill one prescription immediately at a retail pharmacy through Express Scripts.
- Complete a Plan Participant profile and mail it, along with the second prescription from your physician, to the Express Scripts mail service program.

Participant profile forms and self-addressed envelopes for Express Scripts are available from the Human Resources Department or by calling Express Scripts Customer Service; see the Directory of Service Providers for contact information.

Important Terms

This section describes covered services and terms that have significant meaning under the prescription benefit plan.

Formulary: The formulary is a preferred list of the most commonly prescribed medications that have been selected by doctors, pharmacists and other healthcare professionals. The formulary includes brand-name and generic medications that have been approved by the FDA as safe and effective. The medications listed on the formulary are clinically equivalent and possibly more cost effective than other non-formulary medicines.

- ***Generic:*** When a patent on a brand-name medicine expires, the generic equivalent can be made by other manufacturers without the initial start-up costs. As a result, the medicines can be made available to consumers, with the identical chemical composition of the equivalent brand-name medicine, at much lower costs.
- ***Brand Name:*** Brand-name medicines are manufactured by a Company under a registered trademark. Medications are generally more expensive due to the research, development and marketing that is required for introducing a new medicine to the public.

The formulary applies only to prescription medications dispensed to outpatients by participating pharmacies. The formulary does not apply to inpatient medications or to medications obtained from, and/or administered by, a physician.

Non-Formulary: Non-formulary medicines are not preferred for coverage by the carrier and as a result, require a higher copayment.

Physician Preference Program

Your prescription drug plan includes a physician preference program that controls prescription costs by encouraging doctors to use less expensive alternate therapies that are therapeutically equivalent to name-brand drugs. The goal for Express Scripts is to keep your doctor informed of the difference in cost between therapeutically equivalent medicines as well as the differences in daily usage and side effects.

The physician preference program will not affect your doctor's care at all. When a prescription is dispensed to you, either at a retail pharmacy or through the mail, and Express Scripts identifies that a less costly drug might be appropriate, your doctor is contacted. If your doctor agrees to the change, a new prescription is provided to your pharmacy and the alternate medication will be dispensed upon refill. You will also get a letter with information and instructions for your new medication. Under no circumstances is medication changed without your doctor's approval.

Covered Drugs
All prescriptions are covered by your plan, except those which are noted below under *Expenses Not Covered*.

Expenses Not Covered
Coverage will not include:

- blood products,
- breathing devices,
- diagnostic, testing & imaging supplies,
- durable medical equipment,
- fertility agents,
- general anesthetics,
- hair growth agents,
- over-the-counter products & drugs (except for diabetic supplies),
- Retin A (for non-acne treatments)
- serums, toxoids and vaccines,
- over the counter smoking cessation products,
- vitamins (prescription or non-prescription)
- weight management agents.

Important: Also see the *General Exclusions* section.

GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

Criminal Activity/Illegal Act: Any injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation. This exclusion does not apply where such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

Drugs in Testing Phases: Medicines or drugs that are in the Food and Drug Administration Phases I, II, or III testing, drugs that are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Excess Charges: Charges in excess of the Usual, Customary and Reasonable fees for services or supplies provided.

Experimental / Investigational Treatment: Expenses for treatments, procedures, devices, or drugs which the Plan determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

- approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law,
- reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses, and
- reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.

"Reliable evidence" shall include anything determined to be such by the Plan, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the *CMS Medicare Coverage Issues Manual*.

Forms Completion: Charges made for the completion of claim forms or for providing supplemental information.

Government-Operated Facilities: Services furnished to the Covered Person in any veterans hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments. Note: This exclusion does not apply:

- to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government hospital to dependents of active duty armed service personnel or armed service retirees and their dependents, or
- where otherwise prohibited by law.

Late-Filed Claims: Claims that are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

Military Service: Conditions that are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Missed Appointments/Cancellations: Expenses incurred for failure to keep a scheduled appointment.

Never Events: The following list was developed by the National Quality Forum (NQF). Never events are medical errors that should never happen, but when they do, typically cause serious consequences for the patient. By excluding these events, the plan reduces unnecessary costs and eliminates payment for expenses which should not have been incurred. Never events include:

- Surgical Events:
  - surgery performed on the wrong body part,
  - surgery performed on the wrong patient,
  - wrong surgical procedure on a patient,
  - retention of a foreign object in a patient after surgery or other procedure, or
  - intraoperative or immediately post-operative death in a normal, healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative).

- Product or Device Events:
  - patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility,
  - patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended, or
  - patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.
- Patient Protection Events:
  - infant discharged to the wrong person,
  - patient death or serious disability associated with patient elopement (disappearance) for more than four hours, or
  - patient suicide or attempted suicide resulting in serious disability, while being cared for in a healthcare facility.
- Care Management Events:
  - patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration),
  - patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products,
  - maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility,
  - patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility,
  - death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates,
  - Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility, or
  - patient death or serious disability due to spinal manipulative therapy.
- Environmental Events:
  - patient death or serious disability associated with an electric shock while being cared for in a healthcare facility,
  - any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances,
  - patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility,
  - patient death associated with a fall while being cared for in a healthcare facility, or
  - patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility.
- Criminal Events:
  - any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider,
  - abduction of a patient of any age,
  - sexual assault on a patient within or on the grounds of a healthcare facility, or
  - death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility.

No Charge / No Legal Requirement to Pay: Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a "secondary" coverage, this exclusion will apply to those amounts a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts. *Note: This exclusion does not apply to any benefit or coverage that is available through the Medical Assistance Act (Medicaid).*

Services for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

- it must be internationally known as being devoted mainly to medical research, and
- at least 10 percent of its yearly budget must be spent on research not directly related to patient care, and
- at least one-third of its gross income must come from donations for grants other than gifts or payments for patient care, and
- it must accept patients who are unable to pay, and
- two-thirds of its patients must have conditions directly related to the hospital's research.

Not Listed Services or Supplies: Any services, care or supplies that are not specifically listed in the Benefit Document as Eligible Expenses will not be covered unless the expense is substantiated and determined to be Medically Necessary and is approved for coverage by the Plan Sponsor.

Other Coverage: Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules. Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

Outside United States: Charges incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services or supplies. Also excluded are any medical expenses related to such services (i.e., complications arising out of any services intentionally received outside the United States), even if such services are received within United States. *Note: This exclusion will not apply to a Covered Person who obtains emergency services while traveling outside the United States.*

Postage, Shipping, Handling Charges, Etc.: Any postage, shipping or handling charges that may occur in the transmittal of information to the Contract Administrator, as well as interest or financing charges.

Prior Coverage: Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this Benefit Document replaces.

Prior to Effective Date / After Termination Date: Charges incurred prior to an individual's effective date of coverage hereunder or after coverage is terminated, except as may be expressly stated.

Relative or Resident Care: Any service rendered to a Covered Person by a person related by blood or marriage (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Sales Tax, Etc.: Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

Travel: Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included in the list of **Eligible Medical Expenses**.

War or Active Duty: Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law. Conditions caused by a release of nuclear energy, whether or not the result of war.

Work-Related Conditions: Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, whether or not a claim is made for such benefits. If the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

General Facts

COORDINATION OF BENEFITS (COB)

All health care benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

- **Other Plan** - Any of the following that provides benefits or services for health care services:
    - group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured).
    - A "closed panel plan" is a plan that, except in an emergency, provides coverage only in the form of services
    - obtained through a panel of providers that have contracted with or are employed by the plan;
    - medical benefits under group automobile contracts and auto insurance that is subject to a state "no-fault" automobile insurance law. A Covered Person will be presumed to have at least the minimum coverage requirement of the state of jurisdiction, whether or not such coverage is actually in force;
    - Medicare or other governmental benefits, as permitted by law.
    - An "Other Plan" does not include: (1) individual or family insurance, (2) closed panel or other individual coverage (except for group-type coverage), (3) school accident type coverage, (4) benefits for nonmedical components of group long-term care policies, (5) Medicare supplement policies, (6) Medicaid policies or coverage under other governmental plans, unless permitted by law.

NOTES: An "Other Plan" includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them.

If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

- **This Plan** - The coverages of this Plan.
- **Allowable Expense** - A health care service or expense that is covered by This Plan, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., this Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services (an HMO, for example), the reasonable cash value of each service will be considered an Allowable expense and a benefit paid.
- **Claim Determination Period -** A period which commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under this Plan. The Claim Determination Period is the period during which this Plan's normal liability is determined (see "Effect on Benefits Under this Plan").

Note: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., precertification of admissions, second surgical opinion requirements, etc.) will not be considered an Allowable Expense.

Custodial Parent - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

EFFECT ON BENEFITS UNDER THIS PLAN

When Other Plan Does Not Contain a COB Provision - If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC (National Association of Insurance Commissioners) Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be its normal liability or total Allowable Expenses minus benefits paid by the Other Plan(s).

When Other Plan Contains a COB Provision - When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay its normal liability or total Allowable Expenses minus benefits paid by the other Plan(s).

NOTE: The determination of This Plan's "normal liability" will be made on a claim-by-claim basis. No savings or credit reserves will be recognized.

ORDER OF BENEFIT DETERMINATION RULES

Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules.

Medicare as an "Other Plan" - Medicare will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part A and Part B benefits that would have been paid or payable, regardless of whether or not the person was enrolled for such benefits.

Non-Dependent vs. Dependent - The benefits of a plan that covers the Claimant other than as a dependent (i.e., as an employee, member, subscriber or retiree) will be determined before the benefits of a plan that covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan - When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the child's parents are married, (2) the parents are not separated, whether or not they have ever been married, or (3) 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 covered either of the parents longer is primary.

When the Claimant is a dependent child and 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 plan years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

the plan of the Custodial Parent;
the plan of the spouse of the Custodial Parent;
the plan of the noncustodial parent; and then
the plan of the spouse of the noncustodial parent.

Active vs. Inactive Employee - The plan that covers the Claimant as an employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired, is primary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

The plan that covers the Claimant as an active employee or a dependent of an active employee is primary over a plan providing coverage under a right of continuation pursuant to federal or state law (e.g. COBRA). If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage - If none of the above rules establish which plan is primary, the benefits of the plan that has covered the Claimant for the longer period of time will be determined before those of the plan that has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information - For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

Facility of Payment - A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though 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 it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid - or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION OF BENEFITS CLAIM EXAMPLES
MEDICARE PRIMARY PAYOR

Claim One –
Step one – determine what would have been plan payment if MPC was primary plan
Allowed Amount: $123.97
Plan Copay: $25.00
5% Coinsurance: $4.94
Plan payment: $94.02 – if primary carrier
Patient Responsibility: $29.94

Step two – determine what Medicare has paid as the primary carrier
Allowed Amount: $123.97
Medicare Benefit: $99.18 – 80%
Patient Responsibility: $24.79

MPC Payment: $24.79
Patient Responsibility: $0.00

Since Medicare's payment is more than what MPC would have paid, MPC will cover the patient responsibility of $24.79.

Claim Two –
Step one – determine what would have been plan payment if MPC was primary plan
Allowed Amount: $123.97
Plan Copay: $25.00
5% Coinsurance: $4.94
Plan payment: $94.02 – if primary carrier
Patient Responsibility: $29.94

Step two – determine what Medicare has paid as the primary carrier
Allowed Amount: $123.97
Medicare Benefit: $25.00 – due to Medicare deductible requirement
Patient Responsibility: $98.97

MPC Payment: $94.02
Patient Responsibility: $4.94

Since Medicare's payment is less than what MPC would have paid, MPC pays full amount they would have made if they were primary, leaving the balance as patient responsibility of $4.94.

SUBROGATION AND REIMBURSEMENT PROVISIONS

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, Plan Beneficiaries, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

The Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims if the Covered Person(s) fails to file a claim or pursue damages against:

- the responsible party, its insurer, or any other source on behalf of that party,
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage,
- any policy of insurance from any insurance company or guarantor of a third party,
- worker's compensation or other liability insurance company, or
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

If a Covered Person is injured through the act or omission of a third party or Covered Person – and Coverage is or may become available for the payment of claims for treatments, services, and/or supplies ("Services") provided to or received by the Covered Person, arising from injuries, illness, or conditions caused by the aforementioned incident, the Claims Administrator shall, with respect to such Services and in its discretion, provide the applicable benefits described herein, subject to the following:

The covered Person is required to:

1. Notify the Claims Administrator or an agent acting on the Claims Administrator's behalf, in writing, of any actual or potential claim or legal action which such covered Person anticipates bringing or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, or any other payor that may be or may become primarily responsible for payment of the applicable claims, not later than 30 days after submitting or filing a claim or legal action against the third party or determining the identity of responsible third party payors or potentially responsible third party payors, including insurance carriers providing coverage to the Covered Person him or herself;

2. Agree to fully cooperate with the Claims Administrator including execution of any forms or documents needed to assist them in exercising their equitable right to restitution or other available remedies; and

3. Provide the Claims Administrator with an equitable lien, in the amount of reasonable costs of benefits provided. The lien may be filed with any party or parties, as required to protect and enforce these rights, unless otherwise prohibited by law. The lien will be in the amount of benefits paid under this plan for the treatment of the illness, disease, injury or condition for which a third party is liable or responsible for payment, but, not more than the amount allowed by applicable law. Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Persons, such that the death of the Covered Persons, or filing of bankruptcy by the Covered Persons, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to reimbursement.

A Covered Person's failure to comply with 1 through 3, above, shall not in any way act as a waiver, release, or relinquishment of the rights of the Claims Administrator. These rights of reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

When allowed by applicable law, the Plan will recover the maximum amount available, even if the Covered Person has not received adequate funds to compensate them for other damages. When allowed by applicable law, the Plan will not reduce its right to recover funds for attorneys' fees, costs, or other expenses incurred by the Covered Person in pursuing funds from third parties. As such, the Plan seeks to recover the maximum amount allowed in accordance with applicable law, up to but not in excess of 100% of claims paid, and disclaims both the Made Whole and Common Fund Doctrines, and similar rules, whenever it is permissible in accordance with applicable law.

Covered Persons, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee, until the Plan's right to reimbursement is resolved.

In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these reimbursement provisions are concerned. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

In the event that the Covered Person dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the

Covered Persons and all others that benefit from such payment.

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. As a result, the Plan's benefits shall be excess to:
(a) The responsible party, its insurer, or any other source on behalf of that party;
(b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
(c) Any policy of insurance from any insurance company or guarantor of a third party;
(d) Worker's compensation or other liability insurance company; or
(e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Failure by the Covered Person and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Covered Persons may be withheld until the Covered Person satisfies his or her obligation.

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

This provision shall not limit any other remedies of the Plan provided by law. These rights of reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance
If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as provided under the terms of the **Coordination of Benefits** section. The Plan's benefits shall be excess to:

- the responsible party, its insurer, or any other source on behalf of that party,
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage,
- any policy of insurance from any insurance company or guarantor of a third party,
- worker's compensation or other liability insurance company, or
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds
Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death
In the event that the Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations
It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

- to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights,
- to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information,

- to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights,
- to do nothing to prejudice the Plan's rights of subrogation and reimbursement,
- to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received, and
- to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependant upon the Covered Person(s)' cooperation or adherence to these terms.

Offset

Failure by the Covered Person(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person(s) satisfies his or her obligation.

Minor Status

In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Assignments To Providers

All Eligible Expenses reimbursable hereunder will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

No covered Employee or Dependent may, at any time, either while covered hereunder or following termination of coverage, assign his/her right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action that he/she may have against the Plan or its fiduciaries.

Network Providers

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due hereunder, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request. **Important:** In the event the Plan fails to pay benefits to a provider in respect of a claim incurred by a Covered Person, the Employee or Covered Person will be responsible for paying the provider any amounts due for the services received.

Medicaid

Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his/her beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable hereunder.

CLAIMS PROCEDURES

The plan's representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

Definitions

This section uses the following terms:

- **Adverse Benefit Determination:** The term adverse benefit determination means any of the following: a denial, reduction, or termination of a claim for benefits, or a failure to provide or make payment for such a claim (in whole or in part) including determinations of a claimant's eligibility, the application of any review under the Utilization Management Program, determinations that an item or service is experimental/investigational or not medically necessary or appropriate, determinations that the benefit is not covered by the terms of the plan, and determinations that the plan imposes a pre-existing, source of injury, network or other exclusion on otherwise covered benefits.

  An adverse benefit determination includes both pre-service and post-service claims and any rescission of coverage, whether or not there is an immediate adverse effect on any particular benefit.

- **Authorized Representative:** To designate an authorized representative a claimant must provide written authorization on a form provided by the plan, and clearly indicate on the form the nature and extent of the authorization. However, where an urgent care claim is involved, a health care professional with knowledge of the medical condition will be permitted to act as a claimant's authorized representative without a prior written authorization.

- **Benefit Determination:** A benefit determination is the plan's decision regarding the acceptance or denial of a claim for benefits under the plan.

- **Claimant:** A claimant is any plan participant or beneficiary making a claim for benefits. Claimants may file claims themselves or may act through an authorized representative. In this section, the words you and your are used interchangeably with claimant.

- **Concurrent Care Decision:** A concurrent care decision is a decision by the plan regarding coverage of an ongoing course of treatment that has been approved in advance by the plan.

- **Day**: A calendar day.

- **Notice/Notify/Notification:** The terms notice, notify or notification refer to the delivery or furnishing of information to a claimant as required by federal law.

- **Post-Service Claim:** A post-service claim is any claim for a benefit under the plan related to care or treatment that the participant or beneficiary has already received.

- **Pre-Service Claim:** A pre-service claim is any claim that requires plan approval prior to obtaining medical care for the claimant to receive full benefits under the plan. For example, a request for authorization under the Utilization Management Program is a pre-service claim.

- **Urgent Care Claim:** An urgent care claim is any claim for medical care or treatment which, if subject to the normal timeframes for plan determination, could seriously jeopardize the claimant's life, health or ability to regain maximum function or which, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an urgent care claim will be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a physician with knowledge of the claimant's medical condition determines is an urgent care claim as described herein shall be treated as an urgent care claim under the plan. Urgent care claims are a subset of pre-service claims.

Payment of Benefits

All Eligible Expenses reimbursable under the Plan will be paid to the provider(s).

Filing Claims: Time Requirements for a Claimant to File a Claim
A waiver of the following time requirements for filing claims may be made only in the event a claimant is proven to be legally incapacitated.

- **Urgent Care Claims:** In order to file an urgent care claim, you or your authorized representative must call the Utilization Management Program and provide the plan: 1) information sufficient to determine whether, or to what extent, benefits are covered under the plan and 2) a description of the medical circumstances that give rise to the need for expedited review.

  If you or your authorized representative fail to provide the plan with the above information, the plan will provide notice as soon as reasonably possible, but not later than 24 hours after receipt of your claim. You will be afforded a reasonable amount of time under the circumstance, but not less than 48 hours, to provide the specified information.

- **Non-Urgent Pre-Service Claims:** Procedures for filing pre-service claims are discussed in the Utilization Management Program section of this plan.

  Under certain circumstances, if you or your authorized representative fails to follow the plan's procedures for filing a pre-service claim, the plan will provide notice of the failure and the proper procedures to be followed. This notification will be provided as soon as reasonably possible, but not later than 5 days after receipt of the claim. You will then have up to 45 days from receipt of the notice to follow the proper procedures.

- **Post-Service Claims:** In order to file a post-service claim, you or your authorized representative must submit a claim within a 24-month period from the date of the expense that includes the following information:

  - plan participant's name, Social Security number and address;
  - patient's name, Social Security number and address if different from the participant's;
  - provider's name, tax identification number, address, degree and signature;
  - date(s) of service;
  - diagnosis;
  - procedure codes (describes the treatment or services rendered);
  - assignment of benefits, signed (if payment is to be made to the provider);
  - release of information statement, signed;
  - coordination of benefits (COB) information if another plan is the primary payor; and
  - sufficient medical information to determine whether and to what extent the expense is a covered benefit under the plan.

Send complete information to:

Delta Health Systems
Attention: Medical Claims
P.O. Box 80
Stockton, CA 95201

Filing Claims: Status Verifications
Please note that oral or written communications with Delta Health Systems regarding a participant's or beneficiary's eligibility or coverage under the plan are not claims for benefits, and the information provided by Delta Health Systems or other plan representative in such communications does not constitute a authorization of benefits or a guarantee that any particular claim will be paid.

Benefits are determined by the plan at the time a formal claim for benefits is submitted according to the procedures outlined above.

Filing Claims: Time Requirements for Notification of Benefit Determinations
The plan will *notify* you or your *authorized representative* of its *benefit determinations* as follows:

- **Urgent Care Claims:** *Notice* of a *benefit determination* (whether adverse or not) will be provided as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of the claim. However, if the plan gives you *notice* of an incomplete claim, the *notice* will include a time period of not less than 48 hours for you to respond with the requested specified information. The plan will then provide you with the *notice* of *benefit determination* within 48 hours after the earlier of: receipt of the specified information, or the end of the period of time given you to provide the information. If the *benefit determination* is provided orally, it will be followed in writing no later than three days after the oral *notice*.

  If the *urgent care claim* involves a *concurrent care decision*, *notice* of the *benefit determination* (whether adverse or not) will be provided as soon as possible, but not later than 24 hours after receipt of your claim for extension of treatment or care, as long as the claim is made at least 24 hours before the prescribed period of time expires or the prescribed number of treatments ends.

- **Non-Urgent Pre-Service Claims:** *Notice* of a *benefit determination* (whether adverse or not) will be provided in writing within a reasonable period appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. However, this period may be extended one time by the plan for up to an additional 15 days if the plan both determines that such an extension is necessary due to matters beyond its control and provides you written notice, prior to the end of the original 15-day period, of the circumstances requiring the extension and the date by which the plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the *notice* of extension will specifically describe the required information, and you will be given at least 45 days from your receipt of the *notice* to provide the specified information.

  Notice of an adverse benefit determination regarding a concurrent care decision will be provided sufficiently in advance of any termination or reduction of benefits to allow you to appeal and obtain a determination before the benefit is reduced or terminates.

- **Post-Service Claims:** *Notice* of *adverse benefit determinations* will be provided, in writing within a reasonable period of time, but not later than 30 days after receipt of the claim. However, this period may be extended one time by the plan for up to an additional 15 days if the plan both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which the plan expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the *notice* of extension will specifically describe the required information, and you will be given at least 45 days from your receipt of the notice to provide the specified information.

Time Period for Benefit Determination
The applicable time period for the *benefit determination* begins when your claim is filed in accordance with the reasonable procedures of the plan, even if you haven't submitted all the information necessary to make a *benefit determination*. However, if the time period for the *benefit determination* is extended due to your failure to submit information necessary to decide a claim, the time period for making the *benefit determination* will be suspended from the date the *notice* of extension is sent to you until the earlier of the date:

- on which you respond to the request for additional information, or
- established by the plan for the furnishing of the requested information (at least 45 days).

If your claim is denied based on your failure to submit information necessary to decide the claim, the plan may, in its sole discretion, renew its consideration of the denied claim if the plan receives the additional information within 180 days after original receipt of the claim. In such circumstances, you will be *notified* of the plan's reconsideration and subsequent *benefit determination*.

Filing Claims: Information Included in a Notification of Adverse Benefit Determination
If your claim is subject to an *adverse benefit determination*, you will receive a *notification* that includes:

- information identifying the claim involved, including the date of service, the health care provider, and the claim amount;
- the specific reason(s) for the *adverse benefit determination* that includes the denial code and its corresponding meaning and a description of the plan's standard, if any, that was used to deny the claim;
- reference to the specific plan provisions on which the *adverse benefit determination* was based;
- a description of any additional information or material needed from you to complete the claim and an explanation of why it is necessary;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- if the *adverse benefit determination* was based on a *medical necessity*, *experimental/investigational* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
- if an *urgent care claim* was denied, a description of the expedited review process applicable to the claim;
- a description of the plan's review or appeal procedures, including applicable time limits, and a statement of your right to bring suit under federal law with respect to any claim denied after an appeal; and
- contact information for an applicable office of health insurance consumer assistance to assist individuals with the internal claims and appeals (and external review) processes.

The plan will provide a claimant, without cost, with any new or additional evidence considered, relied upon or generated by the plan in connection with the claim. This information will be provided sufficiently in advance to give a claimant time to respond prior to the adverse benefit determination. Any new information for denying a claim on appeal or review also will be disclosed to the claimant sufficiently in advance to allow the claimant time to respond prior to the adverse benefit determination on appeal or review.

First Level Internal Appeals
You or your authorized representative must file any appeal of an adverse benefit determination within 180 days after receiving notification of the adverse benefit determination.

Important: Requests for appeal which do not comply with the following requirements will not be considered.

General Procedures
You or your authorized representative may appeal any adverse benefit determination to the Contract Administrator.

- The Contract Administrator will conduct a full and fair review of all benefit appeals, independently from the individual(s) who made the adverse benefit determination or anyone who reports to such individual(s) and without affording deference to the adverse benefit determination.

- You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. You or your authorized representative will also have the opportunity to submit to the Contract Administrator written comments, documents, records and other information relating to your claim for benefits.

- The Contract Administrator will take into account all this information regardless of whether it was considered in the adverse benefit determination.

If the adverse benefit determination was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are experimental/investigational, or not medically necessary or appropriate, the Contract Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse benefit determination nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the plan in connection with the adverse benefit determination, whether or not the advice was relied upon to make the adverse benefit determination.

Form and Timing for Denied Claims

- **Urgent Care Claim:** You or your authorized representative may appeal an adverse benefit determination of an urgent care claim on an expedited basis, either orally or in writing. You may appeal orally by calling the Plan Sponsor's Utilization Management Program. All necessary information, including the Plan Sponsor's benefit determination on review, will be transmitted between the Plan Sponsor and you by telephone, facsimile, or other available similarly expeditious method.

- **Non-Urgent Pre-Service Claim:** All requests for a review of a denied pre-service claim (other than urgent care claim) must be in writing and should include a copy of the adverse benefit determination, if applicable, and any other pertinent information that you wish the Plan Sponsor to review in conjunction with your appeal. Send all information to:

  Delta Health Systems
  Attention: Benefit Review
  P.O. Box 80
  Stockton, CA 95201

- **Form and Timing:** Denied Post-Service Claim; All requests for a review of a denied post-service claim must be in writing and should include a copy of the adverse benefit determination and any other pertinent information that you wish the Plan Sponsor to review in conjunction with your appeal. Send all information to:

  Delta Health Systems
  Attention: Benefit Review
  P.O. Box 80
  Stockton, CA 95201

Time Requirements for Notification of First Level Appeal
First Level Internal Appeals will be decided by the Plan Sponsor as follows:

- **Urgent Care Claims:** Appeals of *urgent care claims* will be decided by the Plan Sponsor as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan Sponsor receives the appeal. A decision communicated orally will be followed-up in writing no later than three days after the oral *notice*.

- **Other Pre-Service Claims:** Appeals of *pre-service claims* will be decided by the Plan Sponsor within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the *Plan Sponsor* receives the appeal. The *Plan Sponsor's* decision will be provided to you in writing.

- **Post-Service Claims:** Appeals of post-service claims will be decided by the Plan Sponsor within a reasonable period of time, but not later than 30 days after the Plan Sponsor receives the appeal. The Plan Sponsor's decision will be provided to you in writing.

Information Included in a Notification of First Level Appeal
If your appeal is denied, the Plan Sponsor's written *notification* will include:

- the specific reason(s) for the *adverse benefit determination*;

- reference to the specific plan provisions on which the *adverse benefit determination* was based;

- a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information that are relevant to the claim;

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in denying the appeal and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;

- if the denied appeal was based on a *medical necessity*, *experimental/investigational* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and

- a statement describing any additional appeal procedures offered by the plan and your right to obtain information about such procedures, and a statement of your right to bring suit under federal law.

Notification of the decision on an urgent care claim may be provided orally, but a follow-up written notification will be provided no later than three days after the oral notice.

Second Level Internal Appeal of Post-Service Claims
If your appeal of a post-service claim is denied, you or your authorized representative may request further review by the Plan Sponsor. This request for a second-level appeal must be made, in writing, within 60 days of the date you are notified of the original appeal decision. For post-service claims, this second-level review is mandatory, i.e., you are required to undertake this second-level appeal before you may pursue civil action under federal law.

The Plan Sponsor will promptly conduct a full and fair review of your appeal, independently from the individual(s) who considered your first level appeal or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information, as described in more detail under the General Procedures provision above.

If the adverse benefit determination was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are experimental/investigational, or not medically necessary or appropriate, the Plan Sponsor will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the adverse benefit determination nor the initial appeal denial and who is not a subordinate of any such individuals.

Second-level appeals of post-service claims will be decided by the Plan Sponsor within a reasonable period of time, but not later than 30 days after the Plan Sponsor receives the appeal. The Plan Sponsor's decision will be provided to you in writing, and if the decision is a second denial, the notification will include all of the information described in the section, Filing First Level Internal Appeals: Information Included in a Notification of First Level Appeal.

If you remain dissatisfied with the outcome of the second-level review, you may have the right to request an External Review.

External Review
If a claim denial is upheld after the Second Level of Internal Appeal, a claimant may have a right to have the decision reviewed by independent health care professionals who have no association with the Plan if the decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment requested, by submitting a request for external review within four months after receipt of a notice of an adverse benefit determination.

For standard external review, a decision will be made within 45 days of receiving the claimant's request for an external review. If the claimant has a medical condition that would seriously jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function if treatment is delayed, then the claimant may be entitled to request an expedited external review of the denial.

If the denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, then the claimant also may be entitled to file a request for an external review of the denial.

CONTINUATION COVERAGE

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when medical coverage stops, you or your Covered Dependents may be eligible to continue your benefits at your own expense for a temporary period. To be eligible, you and your Covered Dependents must:

- experience a qualifying event that causes the loss of coverage, and
- make an election to continue coverage through COBRA within 60 days of the date shown at the top of the COBRA notification letter (see A*pplying for Coverage*).

The following chart lists qualifying events, who is eligible to continue medical coverage and how long benefits may continue.

Qualifying Event (The reason coverage stopped)	**Who May Continue**	**Continuation Period***
Your employment stops for any reason other than gross misconduct	You and your eligible dependents	18 months
You no longer meet eligibility requirements See *Who Is Eligible* for more information	You and your eligible dependents	18 months
You divorce or legally separate	Ex-spouse/domestic partner and/or eligible dependent children	18 months
Your dependent children no longer meet the eligibly requirements	Former eligible dependents	36 months
You become entitled to Medicare	Eligible dependents	36 months
You die	Eligible dependents	18 months

** A second qualifying event may allow a longer benefit period; see* Multiple Qualifying Events *on the following page for additional information.*

A qualified beneficiary is:

- you, your spouse* and dependent child(ren) enrolled for medical coverage immediately before the qualifying event, and
- a child born, adopted or placed for adoption during the COBRA coverage period.

** Under federal law, domestic partners are not eligible for COBRA coverage*

Qualified beneficiaries who purchase COBRA coverage are able to make changes to their medical coverage during the annual benefits enrollment period. However, if you had only single coverage in effect when you became eligible for COBRA coverage, you may not change to family coverage until the next annual enrollment period unless you experience an event that would allow you to change your coverage during the year (see *Changing Coverage During the Year* for more information).

The benefits provided under COBRA will be the same as those provided to eligible employees, spouses, domestic partners or eligible children who are covered under the MPC plan. If the plans change, benefits under COBRA will also change.

Multiple Qualifying Events

A disabled individual, and all other Covered Dependents, may continue coverage for an additional 11 months, for up to a total of 29 months, if an employee or a dependent is disabled (as defined by the Social Security Administration) within 60 days of a qualifying event and notifies MPC within 60 days of the latest of the date:

- of determination,
- of the qualifying event,
- coverage is lost, and
- the date the qualified individual is informed of the obligation to provide a notice of disability determination.

If the Social Security Administration determines that the disability no longer exists, you or your dependents must notify Human Resources within 31 days. During the extra 11-month period of coverage, premiums may be increased up to 150% of the regular cost of coverage.

If coverage is continued because of a qualifying event for which the continuation period is 18 months, this 18-month period can be extended to 36 months, in the event of a second qualifying event that provides for up to 36 months of extended coverage. For example, an employee terminates employment and purchases continuation coverage for his/her family for up to 18 months. Two months later, one of his/her children reaches the maximum eligibility age. That former dependent child can now purchase continuation coverage for 34 months (36 months minus the two months already received).

If the second qualifying event is that you have become entitled to Medicare, eligible dependents can continue coverage up to 36 months from the date of the first qualifying event.

Applying for Coverage

If one of your dependents loses coverage due to your divorce or legal separation or a dependent no longer meets the eligibility requirements, it is your or your dependent's responsibility to notify MPC and make an election within 60 days of the event. If a COBRA election is not made within the 60-day election period, COBRA coverage will not be available.

Notice for the qualifying events described above must be sent **in writing** (describing the qualifying event and the date it occurred) to:

Delta Health Systems
Attention: Eligibility Department
P.O. Box 80
Stockton, CA 95201

Contact Delta Health Systems at (800) 422-6099 with any questions regarding the COBRA procedures.

In the event of your termination, reduction in your work hours or death, MPC must notify the COBRA Administrator of the qualifying event within 30 days of any of these events. The COBRA Administrator has 14 days to send you a more detailed COBRA Election Notice and Application. To continue coverage under COBRA, you must complete and return the application to the Administrator within 60 days from the later of the date the application is sent to you or the date your coverage would otherwise terminate.

Important: The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

Cost of Coverage

If you or your dependents choose to continue coverage, you will have to pay the full cost of the coverage plus 2% for administrative costs. Your premiums are due on the first of each month. Your first premium payment is due within 45 days of the date you elect COBRA coverage. There is a 31-day grace period for payment of regularly scheduled premiums. If the premium is not paid before the expiration of the grace period, COBRA benefits will end and may not be reinstated.

When COBRA Coverage Ends

Continuation coverage will stop before the maximum continuation period shown at the beginning of this section if one of the following events occurs:

- you or your dependents fail to make timely payments,
- you or your dependents become entitled to Medicare,
- you or your dependents reach your maximum period allowed under COBRA,
- coverage starts under another group health plan, unless coverage is delayed or denied because of a pre-existing condition limitation and you do not have creditable coverage to offset the pre-existing condition, or
- MPC discontinues all medical and prescription benefit plans offered to employees.

Legislation relating to COBRA occasionally changes. This Plan will remain in compliance with all applicable laws or any future Internal Revenue Services (IRS) guidance, even if it conflicts with Plan provisions.

GENERAL PLAN INFORMATION

Requirements	Detailed Information
Name of Plan	Monterey Peninsula College Self-Funded Medical Plan
Plan Sponsor	Monterey Peninsula College 980 Fremont Street Monterey, California 93940. 1-831-645-1392
Plan Sponsor ID Number (EIN)	94-2314506
Plan Number	**501**
Plan Year	July 1 – June 30
Benefit Year	January 1 – December 31
Type of Plan	This is an employee welfare benefit plan providing group benefits
Plan Benefits Described Herein	Self-Funded Medical and Prescription Benefits
Type of Administration	Contract Administration See *Administrative Provisions* for additional information
Contract Administrators ▪ Medical Benefits ▪ Prescription Drugs Benefits	 **Delta Health Systems** 3244 Brookside Road Stockton, CA 95219 **Express Scripts** P.O. Box 66773 St. Louis, MO 63166-6773

ADMINISTRATIVE PROVISIONS

Alternative Treatment Plan
In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan Sponsor elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to provide benefits thereafter in strict accordance with the provisions of the Benefit Document.

Amendment or Termination of the Plan
Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

- reduce, modify or terminate retiree health care benefits under the Plan, if any,
- alter or postpone the method of payment of any benefit,
- amend any provision of these administrative provisions,
- make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA, and
- terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he/she has become entitled under the Plan. In addition, Employees will be provided with advance notice of the change(s), as required by federal law.

Note: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment that is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

Anticipation, Alienation, Sale or Transfer
Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error
Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Contract Administrator
A Contract Administrator is a company that performs all functions reasonably related to the general management, supervision and administration of certain Plan benefits in accordance with the terms and conditions of an administration agreement between the Contract Administrator and the Plan Sponsor. The Plan benefits described herein are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits hereunder.

Creditable Coverage Certificates
Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a “certificate of creditable coverage” or “certificate of group health plan coverage,” from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates, the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

Discrepancies
In the event that there may be a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Benefit Document, the Benefit Document will prevail.

Facility of Payment
Every person receiving or claiming Plan benefits will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he/she can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming Plan benefits is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore.

Fiduciary Responsibility, Authority and Discretion
Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their Plan responsibilities, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Funding
Plan benefits described herein are paid through a trust arrangement with the Employer.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

Illegality of Particular Provision
The illegality of any particular provision of the Benefit Document will not affect the other provisions and the Benefit Document will be construed in all respects as if such invalid provision were omitted.

Indemnification
To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions
No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Benefit Document and Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

Loss of Benefits
To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

- an employee's cessation of active service for the employer,
- a Plan participant's failure to pay his/her share of the cost of coverage, if any, in a timely manner,
- a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces),
- a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party, or
- a claim for benefits is not filed within the time limits of the Plan.

Material Modification
In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

"Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage and generally would include any Plan modification or change that: (1) eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations, (2) increases premiums, deductibles, coinsurance, copays, or other amounts to be paid by a Plan participant or beneficiary, or (3) establishes new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the Plan.

Medicare
Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A & B and Title XVIII of the Social Security Act, and as amended from time to time.

Misstatement / Misrepresentation (Intentional)
If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.
If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his/her eligibility, benefits or both, will be adjusted to reflect his/her true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

See *Termination for Fraud* for additional information and possible implications.

Misuse of Identification Card
If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated on a retroactive basis. See *Termination for Fraud* for additional information and possible implications.

Non-Discrimination Due to Health Status
An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence),
- claims experience,
- receipt of health care,
- medical history,
- evidence of insurability,
- disability, or
- genetic information.

Physical Examination
The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Plan Sponsor Discretion & Authority
The Plan Sponsor (or the delegated Contract Administrator acting within the scope of its delegated authority on behalf of the Plan) shall make determinations regarding Plan benefits.

Privacy Rules & Security Standards: Intent to Comply
To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the “Privacy Rules”) of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with HIPAA Security Standards with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

Purpose of the Plan
The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

Reimbursements

- ***Plan's Right to Reimburse Another Party:*** Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

- ***Plan's Right to be Reimbursed for Payment in Error:*** When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such

overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

- ***Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability:*** The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefor from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Rights Against the Plan Sponsor
The establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Titles or Headings
Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

Workers' Compensation
The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

An Important Note

This booklet describes the major provisions of the medical and prescription benefit plans. More detailed information is available from the plan contracts or other applicable documents (including any certificate of insurance). If there are any conflicts between this Summary Plan Description and the insurance policies (i.e., the official legal documents), the official legal documents will govern.

You have the right to examine a copy of the official Summary Plan Description (including insurance contracts) during regular business hours and to receive a copy of this Summary Plan Description; MPC may make a reasonable charge for providing copies.

Benefit provisions and eligibility for coverage do not constitute a contract of employment with any individual. MPC reserves all rights to end an employment relationship at any time for any reason.

HIPAA STANDARDS FOR PRIVACY

The provisions of this section comply with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and the regulations issued there under, as amended from time to time, including 45 CFR Parts 160 and 164, subparts A and E (HIPAA Privacy Rule) and 45 CFR Parts 160 and 164, subpart C (HIPAA Security Rule).

The Employer/Plan Sponsor has access to the Plan Participant's/Covered Person's individually identifiable health information for administrative functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI).

HIPAA and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI. The following HIPAA definition of PHI applies to this Plan amendment:

Protected Health Information means information, including genetic information, that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Covered Person; the provision of health care to a Covered Person; or the past, present, or future payment for the provision of health care to a Covered Person; and that identifies the Covered Person or for which there is a reasonable basis to believe the information can be used to identify the Covered Person. Protected health information includes information of persons living or deceased.

The Plan Sponsor shall have access to PHI from the Plan only as permitted under this Plan or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to comply with HIPAA's Privacy Standards outlined in this section.

Uses and Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of:

- Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- Modifying, amending or terminating the Plan.

Summary Health Information may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals for whom the Plan Sponsor had provided health benefits under a Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated to the level of a five-digit zip code.

De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Uses and Disclosure of Protected Health Information for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in this subsection and obtaining written authorization pursuant to subsection 3, the Plan may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes.

Plan Administration Purposes means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with the Privacy Standards.

Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, Plan Sponsor shall meet the following conditions:

2. Not use or further disclose PHI other than as permitted or required by the Plan or as Required by Law (as defined in the Privacy Standards);

3. Ensure that any agents or subcontractor, including the Contract Administrator, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

4. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

5. Report to the Plan any PHI use or disclosure that is inconsistent with the Privacy Standards' uses or disclosures provided for, of which the Plan Sponsor becomes aware;

6. Make available PHI to comply with HIPAA's right to access;

7. Make available PHI for Plan amendment and incorporate any amendments to PHI;

8. Make available the information required to provide an accounting of disclosures;

9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (HHS), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance with the Privacy Standards by the Plan;

10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

11. Ensure that adequate separation between the Plan and the Plan Sponsor (i.e. the "firewall"), is established as follows:

    - The Plan Sponsor shall designated employees, or classes of employees, to be given access to the PHI to be disclosed.

    - The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan administration purposes that the Plan Sponsor performs for the Plan.

    - In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan amendment relating to proper use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively as appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Certification of Plan Sponsor
The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- The Plan has been amended to incorporate the provisions of the above section; and

- The Plan Sponsor agrees to the conditions of disclosure set forth in that section.

Disclosure of Certain Enrollment/Disenrollment Information to the Plan Sponsor
The Plan may disclose to the Plan Sponsor information on whether a Covered Person is participating in the Plan, or is enrolled in, or has disenrolled from the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Contract Administrator to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Uses and Disclosures of PHI
With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

ADOPTION OF THE DOCUMENT

Adoption
The Plan Sponsor hereby adopts this Summary Plan Description on the date shown below. This document replaces any and all prior statements of the Plan benefits that are described herein.

Purpose of the Plan
The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan are as listed in the **General Plan Information** section.

Conformity with Law
If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Participating Employers
Employers participating in this Plan are as stated in the section entitled **General Plan Information**.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

Restatement / Replacement of Benefits
This document replaces prior benefits offered by the Plan Sponsor but this is not a new Plan. Except to the extent benefits are expressly added, removed or modified, any benefits provided with respect to covered persons under the prior benefits will be deemed to be benefits provided hereunder for a person who is eligible as an active enrollee or a COBRA enrollee under the document on its effective date. Any contiguous periods a person was covered under the benefits replaced by this document will be deemed to be time covered hereunder.

Acceptance of the Document
We, the Plan Sponsor, recognize that we have full responsibility for the contents of the document and that, while the Contract Administrator, its employees and/or subcontractors, may have assisted in the preparation of the document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee welfare plan.

Acceptance of the Document
IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of January 1, 2012.

Monterey Peninsula College By: _____

Title: _____

WITNESS: By: _____

Title: _____