



CHRISTIAN  
BROTHERS  
SERVICES

**CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST**

**MEDICAL AND PRESCRIPTION DRUG**

**SUMMARY PLAN DOCUMENT**

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## INTRODUCTION

Christian Brothers Employee Benefit Trust is a self-funded church plan that serves employers operating under the auspices of the Roman Catholic Church by providing medical and prescription drug benefits to Plan participants. It is understood that the Trust works within the framework of the tenets of the Roman Catholic Church. It is for this reason the Trust does not provide benefits for services that are not consistent with the position of the Church.

The Trust is comprised of Members which are organizations operating under the auspices of the Roman Catholic Church, and currently listed, or approved for listing, in *The Official Catholic Directory*, published by P.J. Kenedy & Sons. For ease of reference in this Summary Plan Document, these Members are referred to as Employers.

Each of these Members has one or more persons who receive benefits from This Plan. These Participants may include employees, academic employees, members of religious orders, seminarians and secular priests. For ease of reference in this Summary Plan Document, the Participants are referred to as Employees.

**We, Us, and Our** means the Christian Brothers Employee Benefit Trust Trustees or, alternately, the Plan Administrator for specific duties that have been delegated to the Plan Administrator by the Trustees.

### 1. PLAN INFORMATION

#### Plan Name:

Christian Brothers Employee Benefit Trust

#### Plan Sponsor:

Christian Brothers Major Superiors  
c/o Christian Brothers Services  
1205 Windham Parkway  
Romeoville, IL 60446-1679

#### Plan Administrator:

Christian Brothers Services

1205 Windham Parkway  
Romeoville, IL 60446-1679  
Telephone: 800-807-0100  
EIN: 36-3884439

#### Plan Year:

Christian Brothers Employee Benefit Trust is a Calendar Year Plan. Your Plan Year may be different. See Summary of Benefits and Coverage for Your Plan Year specifics.

#### Agent for Service or Legal Process:

Christian Brothers Employee Benefit Trust  
Managing Director, Health Benefit Services  
1205 Windham Parkway  
Romeoville, IL 60446-1679

#### Plan Eligibility and Benefits:

See Eligibility Section and your Summary of Benefits and Coverage to locate a description of medical and prescription drug benefits and eligibility requirements.

#### How to File a Claim:

See Claim Procedures Section.

#### Pharmacy Benefits Manager

Express Scripts, Inc.  
1 Express Way  
St. Louis, MO 63121  
800.718.6601

#### Pharmacy Benefits Manager Initial Coverage Review Department

Express Scripts  
Prior Authorization Dept.  
PO Box 66571,  
St. Louis, MO 63166-6571  
800.753.2851 (phone) 877.329.3760 (fax)  
[www.express-scripts.com/services/physicians/](http://www.express-scripts.com/services/physicians/)



## **Pharmacy Benefits Manager Appeals Department**

Express Scripts  
Attn: Clinical Appeals Department  
PO Box 66588  
St Louis, MO 63166-6588  
800.753.2851  
877. 852.4070 (fax)

## **Pharmacy Benefits External Review Coordinator**

MCMC, LLC  
Attn: Express Scripts Appeal Program  
300 Crown Colony Dr.  
Suite 203  
Quincy, MA 02109  
617.373.7700 x28253  
617.375.7683 (fax)

## **Cost Containment Administrator**

American Health Holdings, Inc.  
7400 West Campus Rd.  
F-510  
New Albany, OH 43054  
866.458.4002

### **A. Plan Benefits**

Plan Benefits are governed by this Summary Plan Document and your Summary of Benefits and Coverage.

### **B. Plan Interpretation**

This Summary Plan Document has been prepared with as much information as is reasonable to help you understand your benefits. However, some terms in This Plan may require interpretation as they apply to a specific situation.

The Plan Administrator has been given the authority and discretion by This Plan's Trustees to interpret the terms of This Plan where This Plan's terms need interpretation and to approve certain services in catastrophic cases.

In interpreting the terms of This Plan, the Plan Administrator relies upon commonly accepted industry practices, as well as experts in the healthcare industry, including its various subspecialties.

### **C. Conformity with State Mandates**

The Christian Brothers Employee Benefit Trust is a “church plan” as designated by the Internal Revenue Service and Department of Labor. It is not a group insurance contract within the meaning of state group insurance laws. Therefore, the Christian Brothers Employee Benefit Trust is not subject to the mandated benefit requirements imposed by state group insurance laws. To the extent that state laws other than those applicable to group insurance contracts may legally require the Christian Brothers Employee Benefit Trust to provide a particular benefit, the Christian Brothers Employee Benefit Trust will conform to the state mandate, unless the mandated benefit would conflict with the doctrine or tenets of the Roman Catholic Church.

### **D. Conformity with Federal Mandates**

The Christian Brothers Employee Benefit Trust is generally subject to the provisions of the Patient Protection and Affordable Care Act. Accordingly, to the extent that Act would legally require the Christian Brothers Employee Benefit Trust to provide a particular benefit, the Christian Brothers Employee Benefit Trust will do so, unless providing the benefit would conflict with the doctrine or tenets of the Roman Catholic Church.

### **E. HIPAA**

The privacy of your health records is protected by specific security and privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, neither This Plan's Sponsor nor the Plan Administrator may release Protected Health Information (PHI) to your Employer, spouse, or any other third party unless required by law or unless you authorize the release. The Plan Notice of Privacy Practices describes This Plan's privacy practices and your rights to access your records. The notice is available on the Christian Brothers Services website in the section relating to HIPAA authorization forms at <https://www.cbsservices.org/hipaa-authorization-forms.html>.

## 2. SUMMARY OF MEDICAL & PRESCRIPTION DRUG BENEFITS

Benefits will be payable during a Plan Year and will vary depending upon whether or not Medically Necessary Care is received from a Hospital, Physician, or other provider who has contracted with the Preferred Provider Organization (PPO) Network. Refer to your Summary of Benefits and Coverage for “What This Plan Covers & What it Costs.” Refer to the remainder of this Summary Plan Document for a complete description of covered and non-covered services.

### A. Comprehensive Medical & Prescription Drug Benefits Payable

**Covered Person** means an Employee, Dependent, or Retiree who is eligible to receive benefits under This Plan and has properly enrolled in This Plan.

If Covered Person has a medical condition resulting from a sickness or injury, Comprehensive Medical & Prescription Drug Benefits will be paid for Covered Charges:

- (1) in excess of the Deductible requirement;
- (2) in excess of the Copayment requirement;
- (3) at the Coinsurance percentage indicated; and
- (4) to the applicable maximum payment limitations as set forth in this Summary Plan Document.

### B. Medical Preferred Provider Organization (PPO)

This Plan contracts with Preferred Provider Organizations (PPO). Each time you need care, you decide whether or not to use a PPO provider. Using a PPO provider saves you and This Plan money, because these contracted providers charge This Plan a discounted rate for services. This means charges from a PPO provider, doctor, or Hospital are discounted, so you and This Plan share the benefit of lower negotiated costs, and you and This Plan pay less for health care.

A listing of participating Hospitals, Physicians, and other providers is available to you via your network’s website. Please refer to the Summary of Benefits and Coverages for PPO Network contact information and PPO and non-PPO levels of benefits.

Please note that your Employer’s PPO selection does not mean that your choice of provider is restricted. You may still seek needed medical care from any Hospital, Physician, or other provider. However, services from providers who are not PPO providers often result in you paying more for the services that you receive and This Plan providing you with a reduced level of benefits. Therefore, you are urged to obtain such care from Preferred Providers whenever possible. Please remember, This Plan does not pay PPO benefits to a non-PPO provider even when a PPO provider refers or requests the assistance of a non-PPO provider, except as described under Medical Emergency.

We have the right to terminate the PPO portion of This Plan if We or the PPO terminate the arrangement. In the event of termination, We will pay the level of benefits for medical care received from non-PPO providers as described in the Summary of Benefits and Coverage.

### C. Prescription Drug Pharmacy Network

Retail Network Pharmacy benefits are designed for short-term drugs, such as antibiotics, or for the first few fills of a long-term Maintenance Drug while you request a fill through the mail order pharmacy. If a Covered Person uses a non-network pharmacy, the allowable charge for prescription drugs will be 80% of the network pharmacy price. Mail order benefits are designed for long-term maintenance prescription drugs that will be taken for more than 90 days. See Summary of Benefits and Coverage for how to locate a Retail Network Pharmacy and for benefits payable for retail and mail prescriptions.

**Retail Network Pharmacy** means the network of pharmacies elected by This Plan provided through the Pharmacy Benefits Manager.

### D. Medical Emergency

If a Covered Person requires Treatment for a Medical Emergency Service and cannot reasonably reach a Preferred Provider, benefits for such Treatment by the Hospital, emergency room Physician, and other charges incurred while being treated in the emergency room will be paid at the same level as a PPO Provider. Prevailing Charges may apply.

**Medical Emergency** means the sudden onset of severe medical symptoms that:

- (1) may be life threatening, cause serious impairment to bodily functions, or dysfunction of any bodily organ; and
- (2) could not have been reasonably anticipated; and
- (3) require immediate medical Treatment on an outpatient basis at a Hospital emergency department.

**Treatment** means confinement, treatment, service, substance, material, or device.

**Urgent Care** is care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life.

**Urgent Care Facility** means a location, distinct from a Hospital emergency department, an office or clinic, that provides Treatment required to prevent serious deterioration of a person's health.

See Summary of Benefits and Coverage under immediate medical attention for the amount you pay for these services, as well as any applicable limitations, exclusions or other important information.

#### **E. Uncontrollable Medical Providers**

For services provided by a non-PPO emergency room Physician, anesthesiologist, radiologist, or pathologist, benefits will be payable at the PPO level when such services are provided at a PPO Hospital (inpatient, outpatient, and Hospital emergency room) or a licensed PPO freestanding surgical center. Prevailing Charges may apply.

#### **F. Medical and Prescription Drug Deductible(s)**

**Deductible** means a specified dollar amount of Covered Charges that must be incurred by a Covered Person before benefits will be payable under This Plan for all or part of the remaining Covered Charges during the year.

Medical and Prescription Drug coverage may have separate or combined Deductibles. See Summary of Benefits and Coverage for applicable Deductible amounts.

All Medical and Prescription Drug Covered Charges (unless otherwise specified) are subject to the Medical and/or Prescription Drug Deductible(s) before benefits are payable for each Covered Person. See Summary of Benefits and Coverage for applicable Deductible amounts.

#### **G. Medical and Prescription Drug Copayment & Coinsurance Amounts**

**Copayment** means the initial amount you owe the provider/supplier for the visit. A Copayment is a set dollar amount.

**Coinsurance** is your share of the cost of covered services. Coinsurance amounts are only applicable to expenses covered by This Plan. Each year, after you satisfy the plan year Deductible (either individual or family), This Plan generally pays a percentage of Covered Charges and you pay a percentage, up to your Out-of-Pocket Expense Maximum(s).

Medical and Prescription Drug Coinsurance and Copayment amounts do not count toward satisfaction of the Medical and/or Prescription Drug Plan Year Deductible(s).

Medical and Prescription Drug Coinsurance and Copayment amounts required count towards the satisfaction of the Plan Year Medical and Prescription Drug Out-of-Pocket Expense Maximum(s).

After the Medical and Prescription Drug Out-of-Pocket Expense Maximum(s) are reached, no further Medical and Prescription Drug Coinsurance or Copayment amounts will be required.

See Summary of Benefits and Coverage for applicable Copayment and Coinsurance amounts.

#### **H. Medical and Prescription Drug Out-of-Pocket Expense Maximum(s)**

Your portion of certain expenses is limited by the Plan's annual Medical and Prescription Drug Out-of-Pocket Expense Maximum(s). If the amount you pay for Covered Charges in any one Plan Year reaches the Out-of-Pocket Expense Maximum(s) as provided in the Summary of

Benefits and Coverage, We will pay 100% of additional Covered Charges (except as described below).

The Deductible, Copayment, and Coinsurance amounts you pay for Covered Charges apply to the Medical and Prescription Drug Out-of-Pocket Expense Maximum(s).

Amounts that are not payable after you reach your Out-of-Pocket Expense Maximum(s) or DO NOT apply toward your Out-of-Pocket Expense Maximum(s) are:

- (1) Amounts above This Plan's Prevailing Charges for covered non-PPO medical expenses;
- (2) Expenses not considered covered medical expenses;
- (3) Amounts in excess of a benefit maximum;
- (4) Deductible, Copayment, or Coinsurance Amounts paid on the Covered Person's behalf by a foundational or manufacturer sponsored patient assistance program;
- (5) Penalties incurred for failure to comply with any Utilization Management Requirements;
- (6) Expenses not considered covered under the prescription drug plan; and
- (7) Penalties incurred for utilizing a non-network pharmacy.

See Summary of Benefits and Coverage for Medical and Prescription Out-of-Pocket Expense Maximum(s).

### **I. Brand Name versus Generic Prescriptions**

Most prescription medications are either Brand Name Prescription Drugs or Generic Prescription Drugs. Both are covered under the program.

**Brand Name Prescription Drug** means a drug that is customarily recognized throughout the pharmaceutical profession as the original or trademarked preparation of a drug entity and for which the Food and Drug Administration (FDA) has given general marketing approval.

**Generic Prescription Drug** means biologically equivalent pharmaceutical products manufactured and sold under their chemical, common or non-proprietary official name.

The mail order pharmacy will automatically fill your prescription with a Generic Prescription Drug (if available), regardless of whether you or the prescribing Physician requests the Brand Name Prescription Drug be dispensed.

Certain Brand Name drugs will be Preferred, meaning they are included on the Formulary. Non-Preferred Drugs may have higher costs under This Plan.

### **J. Generic Drug Substitution**

When a Generic Prescription Drug is available, but the pharmacy dispenses a Brand Name medication upon your or your Physician's request, you will pay the difference between the Brand Name medication and the Generic medication, plus the Brand Name Copayment. The additional cost you pay for filling a prescription with a Brand Name medication when a Generic equivalent is available does not apply to the Out-of-Pocket maximum. If the plan year Out-of-Pocket maximum is reached, the Plan will pay 100% of any covered medications for the remainder of the year. However, you would continue to be responsible for paying the cost difference for any Brand Name prescriptions that are filled when a Generic equivalent is available.

## **3. ELIGIBILITY**

You may be eligible to participate in This Plan if you are an Employee who is employed by an Employer that participates in This Plan. If you are eligible to participate in This Plan, your Dependents may also be eligible to participate in This Plan.

### **A. Who is Eligible**

**Covered Person** means an Employee or Dependent eligible to receive benefits under This Plan.

**Employee** means an eligible employee of an Employer whose work week meets the minimum requirements as determined by the Employer. In no event can an employee be eligible for This Plan who works fewer than 20 hours in a normal work week.

For an academic employee, Employee includes an academic employee who meets the requirements as determined by the Employer. In no event can an academic employee be eligible for This Plan who teaches less than 1/2 of a normal work load.

Employee may include members of religious orders, seminarians and secular priests.

Employee does not include temporary employees, employees who do not meet the above criteria, independent contractors, volunteers, etc., whose income from the Employer is not subject to Federal Withholding for wages or FICA, except in case of vowed religious.

**Employer** means any corporation, establishment, or institution that has fulfilled participation requirements of the Trust and:

- (1) is operated under the auspices of the Roman Catholic Church, in good standing thereof, and is currently listed, or approved for listing, in *The Official Catholic Directory*, published by P.J. Kenedy & Sons; and
- (2) is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986, as amended; and
- (3) is organized as a not-for-profit corporation, if the organization is a corporation.

**Dependent** means:

- (1) your Spouse, if not in the Armed Forces and not covered as an Employee;
- (2) your natural or legally adopted child under 26 years of age;
- (3) a child of your Spouse under 26 years of age; and
- (4) a child under 26 years of age for whom you have legal guardianship.

Dependent also includes any child covered under a Qualified Medical Child Support Order or National Medical Support Notice as defined by applicable federal law and state insurance laws applicable to This Plan, provided the child otherwise meets This Plan's definition of a Dependent.

In no event may a Dependent child be covered by more than one Employee.

A covered child, who attains the age at which status as an eligible Dependent would otherwise terminate, may retain eligibility if the Dependent is chiefly reliant upon the Employee for support and maintenance and incapable of self-sustaining employment by reason of Physical Disability. Such condition must start before reaching the age when the child's Dependent status otherwise would terminate. We may ask for proof of incapacity from time to time. If proof is requested and We do not receive the requested information within 90 days, the child will no longer be considered an eligible Dependent.

**Physical Disability** means a Dependent child's substantial physical or mental impairment which:

- (1) results from injury, accident, congenital defect, or sickness; and
- (2) is diagnosed by a Physician as a permanent or long term dysfunction or malformation of the body.

A non-covered child who is ineligible due to age may be eligible for coverage under this Physical Disability provision if the child meets the requirements above.

**Spouse** means a person who is legally married to the Employee.

## **B. When You are Eligible for Coverage**

If you are an Employee, as defined, you are eligible for coverage the day This Plan goes into effect at your Employer's location. If your employment commences after such date, you are eligible for coverage on the date selected by your Employer following the commencement of your employment.

## **C. When Your Dependents are Eligible for Coverage**

Your Dependents are eligible for coverage the same day as you, provided that you have eligible Dependents on that date. If you later acquire a Dependent, that Dependent is eligible for coverage on the date acquired.

## **D. Newborns**

Your newborn child will be automatically covered until the child attains 31 days of age. If you do not enroll this child for Dependent coverage before the end of the 31 days, no further benefits will be available. Enrollment will be delayed until the next open enrollment period, as defined by your Employer, unless a Special Enrollment Provision is met.

## **E. How You Enroll for Coverage**

To enroll for coverage, obtain an enrollment form from your Employer. Complete the form providing all requested information applicable to you and your Dependents. Sign the form and return to your Employer on a timely basis.

## **F. When You Become Enrolled for Coverage**

### **1) Noncontributory Coverage**

If no contributions are required from you for the coverage, you are covered the first day you are eligible.

If no contributions are required from you for Dependent coverage, your Dependents will be covered on the first day you are eligible for Dependent coverage.

### **2) Contributory Coverage**

If contributions are required from you for the coverage, coverage begins on the first day you become eligible. If you delay your enrollment more than 31 days beyond the date you were first eligible, then your enrollment is delayed until the next open enrollment period as defined by your Employer, unless you meet Special Enrollment Provisions.

If contributions are required from you for Dependent coverage, your Dependent will be covered on the first day you become eligible. If you delay Dependent enrollment more than 31 days beyond the date the Dependent was first eligible, then your Dependent enrollment is delayed until the next open enrollment period as defined by your Employer, unless your Dependent meets Special Enrollment Provisions.

### **3) Special Enrollment Provisions**

If you or your Dependent request enrollment after the first period in which you or your Dependent were eligible to enroll, you or your Dependent must meet the Special Enrollment Provisions.

The Special Enrollment Provisions are:

#### **a) Loss of Other Coverage**

A Special Enrollment Provision will apply to you or your Dependent if all of the following conditions are met:

- (1) You or your Dependent were covered under another Group Health Plan or had other Health Insurance Coverage at the time of initial eligibility, and declined enrollment solely due to the other coverage.
- (2) **Health Insurance Coverage** means benefits consisting of medical care, prescription drugs, dental care, or vision care, provided directly, through insurance or reimbursement, or otherwise, under any Hospital or medical service policy or certificate, Hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health Insurance Coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.
- (3) The other coverage terminated due to loss of eligibility (including loss due to legal separation, divorce, death, cessation of Dependent status, termination of employment or reduction in work hours, incurring a claim that meets or exceeds the other coverage Lifetime Benefit Maximum on all benefits, when the individual no

longer resides, lives, or works in a service area and there is no other benefit package available under the other Group Health Plan, or when the other Group Health Plan no longer offers any benefits to a class of similarly situated individuals), or due to termination of Employer contributions (or, if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation).

- (4) Request for enrollment is made within 31 days after the other coverage terminates or after a claim is denied due to reaching the Lifetime Benefit Maximum of all benefits under the other health coverage.

The effective date of coverage will be the date as determined by your Employer.

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

#### ***b) Newly Acquired Dependents***

A Special Enrollment Provision will apply to you or your Dependent if all of the following conditions are met:

- (1) You are enrolled (or are eligible to be enrolled but have failed to enroll during a previous enrollment period);
- (2) A person becomes your Dependent through marriage, birth, adoption or placement for adoption; and
- (3) Request for enrollment is made within 31 days after the date of the marriage, birth, adoption, or placement for adoption.

The effective date of you or your Dependent's coverage will be as follows:

- (4) In the event of marriage, the date of marriage or first of following month;

- (5) In the event of a Dependent child's birth, the date of such birth;
- (6) In the event of a Dependent child's adoption or placement for adoption, the date of such adoption or placement for adoption, whichever is earlier.

#### ***c) Court-Ordered Coverage***

A Special Enrollment Provision will apply to your Dependent child if all of the following conditions are met:

- (1) You are enrolled but have failed to enroll the Dependent child during a previous enrollment period;
- (2) You are required by a court or administrative order to provide health coverage for the Dependent child; and
- (3) Request for enrollment is made within 31 days after the issue date of the court or administrative order.

The effective date of the Dependent child's coverage will be the date of the court order.

A copy of the procedures governing Qualified Medical Child Support Orders (QMCSO) can be obtained from the plan administrator without charge.

#### ***d) Loss of Medicaid or CHIP Coverage***

A Special Enrollment Provision may apply to you or your Dependent if all of the following conditions are met:

- (1) You or your Dependent is covered under Medicaid or a Children's Health Insurance Program ("CHIP") and Medicaid or CHIP coverage is terminated as the result of loss of eligibility; and
- (2) You request special enrollment on an appropriately completed enrollment application within 60 days after the loss of such coverage.

#### ***e) Eligibility for Employment Assistance Under Medicaid or CHIP***

A Special Enrollment Provision may apply to you or your Dependent if all of the following conditions are met:

- (1) You or your Dependent become eligible for a Medicaid or CHIP premium assistance subsidy; and
- (2) You request special enrollment within 60 days after you or your Dependent is determined to be eligible for assistance.

### **G. Change in Family Status**

Once you are enrolled in This Plan, You must promptly enroll your eligible Dependents. You must also notify your Employer when you no longer have any eligible Dependents.

You must report the names, social security numbers and dates of birth of all eligible Dependents to your Employer.

### **H. When Your Coverage Terminates**

Coverage for you and your Dependents terminate when:

- (1) your employment terminates; or
- (2) you no longer qualify as an Employee; or
- (3) coverage terminates for the class of Employees to which you belong; or
- (4) you discontinue required contributions; or
- (5) you cease to be actively employed; or
- (6) your Employer no longer participates in the Trust; or
- (7) This Plan terminates.

Coverage for a Dependent terminates when:

- (1) your Dependent is no longer eligible for coverage; or
- (2) your Dependent's coverage under This Plan terminates; or
- (3) your coverage as an Employee terminates; or
- (4) This Plan terminates.

### **I. Continuation Privilege**

Any continuation privileges below are subject to terms and conditions established by your Employer and the Plan Administrator.

#### **1) Employee and Dependent Continuation Privilege**

If you or your Dependents lose coverage due to:

- (1) termination of employment; or
- (2) leave of absence; or
- (3) ineligibility as an Employee; or
- (4) ineligibility as a Dependent; or
- (5) retirement; or
- (6) death of an Employee or Retiree; or
- (7) disability; or
- (8) divorce;

you may be eligible to continue your medical and prescription drug coverage for a limited period of time by paying the required contribution as long as you or your dependents are not enrolled in another qualifying Group Health Plan.

You should contact your Employer to verify if continuation is available and to obtain the necessary forms.

#### **2) Retiree Continuation Privilege**

Your Employer may offer a Retiree Continuation Privilege. Please contact your Employer to verify if continuation is available.

If your Employer allows continuation for retirees, you and your eligible Covered Dependents may be eligible to continue your Medical and Prescription coverage by paying the required contribution. You would be eligible if you retire at age 55 or older with at least five consecutive years of Medical coverage under This Plan prior to retirement.

Contact your Employer immediately upon retirement to obtain the necessary forms for continuation.

If you die while under the Retiree Continuation Privilege, your eligible Covered Dependents may be eligible to continue their coverage for a limited period of time by paying the required contribution.

If a retiree, or Spouse, is eligible for Medicare and chooses not to purchase Medicare A or B, benefits from This Plan will be reduced. This



Plan only provides benefits as outlined under the Integration with Medicare provision.

### 3) *Federal Family and Medical Leave Act (FMLA) Continuation*

Federal law requires that Employees eligible for benefits under the Federal Family and Medical Leave Act (FMLA) be provided a continuation period in accordance with the provisions of the FMLA.

See your Employer to determine whether you qualify for benefits under FMLA and, if so, the terms of any continuation period.

If FMLA applies to your coverage, these FMLA continuation provisions:

- (1) are in addition to any other continuation provision of This Plan, if any; and
- (2) will run concurrently with any other continuation provisions of This Plan for illness, injury, layoff, or approved leave of absence, if any.

If you qualify for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction under both.

### 4) *Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) Continuation*

Federal law requires that if your coverage would otherwise end because you enter into active military duty, you may elect to continue coverage (including Dependent coverage) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If active employment ends because you enter active military duty, coverage may be continued until the earliest of:

- (1) for you and your Dependents:
  - the date the group plan is terminated; or
  - the end of the contribution period for which contributions are paid if you fail to make payment of a required contribution on a timely basis; or

- the date 24 months after the date you enter active military duty; or
- the date after the day on which you fail to return to active employment or apply for reemployment with the Employer.

(2) for your Dependents:

- the date Dependent Coverage would otherwise cease; or
- any date desired, if requested by you before that date.

The continuation provision will be in addition to any other continuation provisions described in This Plan for illness, injury, layoff, or approved leave of absence, if any. If you qualify for both state and USERRA continuation, the election of one means the rejection of the other.

The reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

This is a general summary of the USERRA and how it affects your group plan. See your Employer for further details on this continuation period.

## J. Rescission

Coverage may be cancelled or discontinued retroactively if an individual (or an individual seeking coverage on behalf of an individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. A cancellation or discontinuance of coverage is not a rescission to the extent it is attributable to a failure to pay required contributions on a timely basis toward the cost of coverage.

#### 4. COMPREHENSIVE MEDICAL COVERAGE

Comprehensive Medical Benefits are designed to help pay expenses for Covered Charges which you would otherwise have to pay in full.

##### A. Lifetime Benefit Maximum

This Plan has no overall Lifetime Medical Benefit Maximum and it has no Lifetime Prescription Drug Benefit Maximum.

This Plan incorporates other yearly or Lifetime Benefit Maximums for each Covered Person. These maximums or limitations are outlined in the description of the specific benefit.

##### B. Medical Benefits Payable

Benefits payable are for Covered Charges, described in this section, and are subject to:

- (1) utilization management requirements
- (2) all listed limitations; and
- (3) the terms and conditions of:
  - Coordination with Other Benefits; and
  - Reimbursement/Subrogation.

##### C. Covered Charges

**Covered Charges** means a Treatment that is Medically Necessary.

**Medically Necessary** means a Treatment that meets all of the following criteria:

- (1) prescribed by a Physician and required for the screening, diagnosis or Treatment of a medical condition;
- (2) consistent with the diagnosis or symptoms;
- (3) not excessive in scope, duration, intensity or quantity;
- (4) the most appropriate level of services or supplies that can safely be provided;
- (5) determined by Us to be Generally Accepted; and
- (6) is not an Experimental or Investigational Measure.

**Generally Accepted** means Treatment for the particular sickness or injury which is the subject of the claim that meets all of the following criteria:

- (1) has been accepted as the standard of practice according to the prevailing opinion among experts as shown by articles published in authoritative, peer-reviewed medical and scientific literature;
- (2) is in general use in the relevant medical community; and
- (3) is not under scientific testing or research.

**Experimental or Investigational Measure** means any Treatment, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field, as determined by Us.

**Prevailing Charges** means Covered Charges which are identified by the Plan Administrator, taking into consideration the charge which the provider most frequently bills to the majority of patients for the service or supply, the cost to the provider for providing the service or supply, the usual range of charges billed in the same area by providers of similar training and experience for the service or supply, and/or the Medicare reimbursement rates. **Area** means, as appropriate, a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such Treatment, service, or supply for which a specific charge is made. To be Prevailing Charges, the charge must be in compliance with the Plan Administrator's policies and procedures relating to billing practices for unbundling or multiple procedures.

Covered Charges, as defined, will be the actual cost charged to the Covered Person, but only to the extent that the actual cost charged does not exceed Prevailing Charges for:

- (1) Hospital room and board (but not more than the Private Room Maximum, if confinement is in a private room);
- (2) Hospital services other than room and board;
- (3) Birthing Center services;
- (4) Ambulatory Surgery Center services;

- (5) the services of a Physician, including Physician Visits; and
- (6) any other Covered Charges set forth in this Summary Plan Document.

**Ambulatory Surgery Center** means a facility designed to provide surgical care which does not require Hospital Inpatient Confinement but is at a level above what is available in a Physician’s office or clinic and meets all of the following criteria:

- (1) is licensed by the proper authority of the state in which it is located, has an organized Physician staff, and has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- (2) provides Physician services and full-time skilled nursing services directed by a Nurse whenever a patient is in the facility;
- (3) does not provide the services or other accommodations for Hospital Inpatient Confinement; and
- (4) is not a facility used as an office or clinic for the private practice of a Physician or other professional providers.

**Birthing Center** means a freestanding facility that is licensed by the proper authority of the state in which it is located and that meets all of the following criteria:

- (1) operates within the scope of all required licenses;
- (2) provides prenatal care, delivery, and immediate postpartum care;
- (3) operates under the direction of a Physician who is a specialist in obstetrics and gynecology;
- (4) has a Physician or Certified Nurse Midwife present at all births and during the immediate postpartum period;
- (5) provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a Nurse or Certified Nurse Midwife;
- (6) has a written agreement with a Hospital in the area for emergency transfer of a patient or a newborn child,

with written procedures for such transfer being displayed and staff members being aware of such procedures; and

- (7) maintains written medical records for each patient.

**State Licensed Mental Health Provider** means a provider who:

- (1) is licensed or certified and practices within the State of the license or certification;
- (2) is treating a mental health, alcohol, or drug abuse condition; and
- (3) is practicing within the scope of his or her license.

**Nurse** means a nurse who is licensed or certified by the State in which he or she practices. This includes both a Registered Nurse (R.N.) and a Licensed Practical Nurse (L.P.N), but does not include an Advanced Practice Registered Nurse.

**Physician** means Doctor of Medicine; Doctor of Osteopathy; Advanced Practice Registered Nurse; Dentist; Physician’s Assistant; Podiatrist, Chiropractor, Psychologist, State Licensed Mental Health Provider, and Licensed Social Worker.

**Physician Visit** means a face-to-face meeting, or a virtual exchange in the case of established patients, between a Physician, Health Care Extender, or State Licensed Practitioner, and a patient for the purpose of Treatment.

**Primary Care Physician** is a family or general practitioner, internist (internal medicine), obstetrician/gynecologist, pediatrician, Certified Nurse Midwife, Nurse Practitioner, geriatric Physician, or a Nurse or Physician assistant directed and supervised by a Primary Care Physician. This Plan does not require you to select a Primary Care Physician.

**Specialty Care Physician** is a Physician who is not a Primary Care Physician.

**D. Covered Charges for an Assistant during Surgical Procedures**

Benefits will be payable for the services of an assistant to a surgeon if the skill level of a Medical Doctor or Doctor of Osteopathy is required

to assist the primary surgeon. Covered Charges for such services will be paid up to 20% of the Prevailing Charges of the covered surgical procedure if the procedure is performed by a Physician or a Health Care Extender.

#### E. Covered Charges for Multiple Surgical Procedures

If two or more surgical procedures are performed during any one time, Covered Charges for the services of the Physician for each procedure that is clearly identified and defined as a separate procedure will be based on:

- (1) 100% of Prevailing Charges for the first or primary surgical procedures; and
- (2) 50% of Prevailing Charges for the second surgical procedures; and
- (3) 25% of Prevailing Charges for each of the other surgical procedures.

#### F. Other Covered Charges

Benefits will be payable for:

- (1) the services of a Nurse, but only when such services are provided during confinement in a Hospital or Skilled Nursing Facility, or when such services are provided as part of Home Health Care or Hospice Care.
- (2) the services of a licensed physiotherapist.
- (3) the services of a qualified speech therapist, occupational or physical therapist to provide Habilitation or Rehabilitation services for a Covered Person. See Summary of Benefits and Coverage for maximum visit limits.

**Habilitation** means health care services that help a person keep, learn or improve skills and functions for daily living.

**Rehabilitation** means the treatment of disease, injury, or other cause, by physical agents and methods to assist in the restoration of normal

physical bodily function, that is goal oriented where the Covered Person has potential for functional improvement and the ability to progress.

- (4) anesthesia, blood, blood plasma, and oxygen.
- (5) X-ray and laboratory examinations.
- (6) the services for genetic testing if the testing meets This Plan's criteria and is pre-approved by Us.
- (7) X-ray, radium, and radioactive isotope therapy.
- (8) surgical dressings, casts, splints, braces, crutches, artificial limbs, and artificial eyes.
- (9) preventive care as required by federal law.
- (10) infertility Treatment but limited to initial lab tests, hysterosalpingogram, hysteroscopy, pelvic ultrasound, and transvaginal ultrasound for the restoration of fertility or the promotion of conception.
- (11) services for a diabetic self-management program for a Covered Person who has been newly diagnosed with Diabetes Mellitus, or has new complications thereof. Such program should be pre-approved by Us and the program must be well defined or have received American Diabetes Association approval.
- (12) the services of an Advanced Practice Registered Nurse, but only when such services are provided in lieu of a Physician.

**Advanced Practice Registered Nurse** means a Nurse with advanced education at the masters or doctoral levels who possesses advanced training, knowledge, skills, and certification and/or licensure and includes Nurses such as a Certified Nurse Anesthetist, Certified Nurse Midwife, and Nurse Practitioner.

- (13) Dental Services to repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and the Dental Services are completed within twelve months after the accident, and not covered by your dental plan.

Covered Charges are limited to the least expensive procedure that would provide professionally acceptable results.

**Dental Services** means any confinement, Treatment, or service to diagnose, prevent, or correct periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth); and malocclusion (abnormal positioning and/or relationship of the teeth); and/or craniomandibular or temporomandibular joint disorders; and/or ailments or defects of the teeth and supporting tissues and bone (excluding appliances used to close an acquired or congenital opening). However, the term Dental Services will include Treatment performed to replace or restore any natural teeth in conjunction with the use of any such appliance.

(14) the services of a Health Care Extender.

**Health Care Extender** means a member of a covered provider's staff or allied health practitioner. Medical services must be billed by and delivered under the Direction and Supervision of a provider covered by This Plan.

**Direction and Supervision** means the covered provider bills for and co-signs any progress notes written by the Health Care Extender; or there is a legal agreement that places overall responsibility for the Health Care Extender's services on the provider.

(15) Federal Legend drugs and medicines requiring a Physician's prescription which are not eligible under the Prescription Drug Coverage.

(16) transportation services by ambulance provided by a Hospital or licensed service to a local Hospital, to the nearest Hospital equipped to furnish needed Treatment not available in a local Hospital, or when needed to transition to a more cost effective level of care as determined by Us. This Plan will pay Preferred Provider (PPO) benefit levels for transportation by ambulance regardless of whether such service is provided by a PPO or non-PPO provider. For non-PPO providers, Prevailing Charges may apply. For ambulance service

in which total charges exceed \$5,000 by ground and/or air, payment by This Plan will not exceed 150 percent of the Medicare allowance for all charges. Charges include those which relate to: 1) transportation and 2) medical supplies used during transport, including those for Basic Life Support only services and Advanced Life Support services and supplies.

(17) rental or purchase of Durable Medical Equipment (DME). The maximum charges eligible for consideration for rental of DME will be limited to the purchase price. When We determine whether to purchase or rent the equipment, We will consider the type of equipment requested, and the condition and length of time for which it will be used. Eligible equipment is a breast pump, nebulizer, commode, walker, manual wheelchair, or standard Hospital -type bed. Other DME may be eligible after Our review, but We must pre-approve the requested equipment.

**Durable Medical Equipment** means equipment that can withstand repeated use; and is primarily and customarily used to serve a medical purpose; and is generally not useful to a person who is not sick or injured, or used by other family members; and is appropriate for home use; and improves bodily function caused by sickness or injury, or further prevents deterioration of the medical condition. Durable Medical Equipment also means the repair, adjustment, or replacement of covered purchased Durable Medical Equipment, unless damage results from you or your Dependent's negligence or abuse of such equipment.

(18) convalescent care charges by a Skilled Nursing Facility for room, board, and other services required for Treatment. Confinement must be certified by a Physician as necessary for recovery from a sickness or injury and follow three or more consecutive days of Hospital Inpatient Confinement for which comprehensive Medical Benefits were paid. Confinement must be a direct result of the sickness or injury that was the cause of the Hospital Inpatient Confinement. Confinement must

begin no later than 14 days after the end of the Hospital confinement or no later than 14 days after the end of a prior Skilled Nursing Facility confinement for which Comprehensive Medical Benefits were paid. Covered Charges for each day will not be more than 50% of the Private Room Maximum of the Hospital in which the Covered Person was confined before the Skilled Nursing Facility confinement. In addition, Covered Charges will not include any charges after the date the attending Physician stops Treatment or withdraws certification. See Summary of Benefits and Coverage for maximum days confinement limits.

**Skilled Nursing Facility** means an institution that is licensed to provide skilled nursing care for persons recovering from sickness or injury and: is supervised on a full-time basis by a Physician or a Nurse; and has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one Physician; and has a contract for the services of a Physician, maintains daily records on each patient and is equipped to dispense and administer drugs; and provides 24-hour nursing care and other medical Treatment. Not included are rest homes, homes for the aged, or Residential Treatment Facilities.

**Private Room Maximum** means Covered Charges by a Hospital for room and board while confined in a private room up to the Hospital's most frequent semiprivate room rate, if the Hospital has semiprivate rooms; or the Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

- (19) charges for Home Health Care including charges by a Home Health Care Agency, for: part-time or intermittent home nursing care by or under the supervision of a Nurse; and part-time or intermittent home care by a Home Health Aide; and physical, occupational, or speech therapy; and drugs and medicines (requiring a Physician's prescription), and other supplies prescribed by the attending Physician, if the cost of these items would have been Covered Charges had the Covered

Person remained as an inpatient in the Hospital; and laboratory services by or for a Hospital if the cost of these services would have been Covered Charges had the Covered Person remained as an inpatient in the Hospital. Only the services and supplies provided under the terms of a Home Health Care Plan are covered.

**Home Health Care Plan** means a program of home care that: is required as a result of a sickness or injury; and follows a period of Hospital confinement; and is a result of the sickness or injury that was the cause of the Hospital Inpatient Confinement; and is established in writing by the attending Physician within seven days after Hospital Inpatient Confinement ends; and is certified by the attending Physician as a replacement for Hospital Inpatient Confinement that would otherwise be necessary. One Home Health Care visit will be counted for up to four hours of service (in a 24-hour period) by a Home Health Aide and one visit will be counted for each visit by any other person. See Summary of Benefits and Coverage for maximum visit limits.

**Home Health Aide** means a person, other than a Nurse, certified by the state to provide medical or therapeutic care under the supervision of a Home Health Care Agency.

**Home Health Care Agency** means an agency or other service that is certified by the proper authority of the state in which it is located to provide home health care.

- (20) charges for Hospice Care Services as approved by the attending Physician and Us provided by a Hospice, Hospice Care Team (a group that provides coordinated Hospice Care Services and normally includes a Physician, a patient care coordinator (Physician or Nurse who serves as an intermediary between the program and the attending Physician), a Nurse, a mental health specialist, a social worker, a chaplain, and lay volunteers), Hospital, Home Health Care Agency, or Skilled Nursing Facility for any sick or injured Covered Person who, in the opinion of the attending Physician, has no reasonable prospect of cure and is expected to live no

longer than six months; but only to the extent that such Hospice Care Services are provided under the terms of a Hospice Care Program and are billed through the Hospice that manages that program. See Summary of Benefits and Coverage for maximum day limits.

**Hospice Care Program** means a coordinated, interdisciplinary program that provides services that consist of inpatient and outpatient care, home care, nursing care, counseling, and other supportive services and supplies provided to meet the physical, psychological, spiritual, and social needs of the dying Covered Person; and drugs and medicines (requiring a Physician's prescription) and other supplies prescribed for the dying Covered Person by any Physician who is a part of the Hospice Care Team; and instructions for care of the patient, counseling, and other supportive services for the family of the dying Covered Person.

- (21) charges for acupressure, acupuncture, and massage therapy services provided by a State Licensed Practitioner. See Summary of Benefits and Coverage for limitation of State Licensed Practitioner Benefit.

**State Licensed Practitioner** means a provider who is licensed or certified and practices within the state of the license or certification; and is treating a medical condition; and is practicing within the scope of his or her license; and is not specifically covered under any other provisions of the medical plan.

- (22) charges to assist Covered Persons with their nutritional needs for the Treatment of a covered illness if such Treatment meets Plan criteria and is ordered by a Physician and provided from a state licensed dietician. See Summary of Benefits and Coverage for limitation of State Licensed Practitioner Benefit.
- (23) counseling services or visits performed by a covered provider or an individual trained and certified in natural family planning. Charges will be reimbursed to you at 100% up to a \$200 yearly maximum. We will require

proof of payment and an itemized billing with a diagnosis code confirming Treatment for natural family planning.

- (24) charges for the purchase of orthotics when they are prescribed for a specific diagnosed medical condition, such as, but not limited to: bone spurs, heel spurs or plantar fasciitis. Covered Charges will include testing and casting related to the purchase of the orthotics. See Summary of Benefits and Coverage for maximum limitation.
- (25) charges related to pregnancy. The mother and newborn are considered as separate Covered Persons under This Plan and separate Deductibles and Out-of-Pockets will apply. Maternity benefits include services which are considered to be the Generally Accepted standard of care as well as benefits for three routine obstetrical ultrasounds. Any additional ultrasounds must be reviewed to determine if they will be considered Medically Necessary Covered Charges.
- (26) Transplant Benefits only as described under Organ and Tissue Transplant Benefits.

### **G. Organ and Tissue Transplant Benefits**

**Transplant Benefits** means Covered Charges incurred in connection with the Covered Transplants listed below that are necessary and required for Treatment and not considered to be an Experimental or Investigational Measure.

**NOTE: IN ORDER FOR YOU TO RECEIVE THE MAXIMUM PLAN BENEFITS, YOU MUST CONTACT YOUR COST CONTAINMENT ADMINISTRATOR, WHO WILL HAVE A TRANSPLANT COORDINATOR CONTACT YOU OR YOUR PROVIDER.**

#### *1) Covered Transplant*

**Covered Transplants** include the following human-to-human organ or bone marrow transplant procedures and will be considered Covered

Charges, subject to all limitations and maximums described in this section and the Summary Plan Document, for a Covered Person under This Plan.

- (1) Heart;
- (2) Heart/Lung (simultaneous);
- (3) Lung;
- (4) Liver;
- (5) Kidney;
- (6) Pancreas;
- (7) Kidney/Pancreas (simultaneous);
- (8) Small Bowel;
- (9) Bone marrow transplant or peripheral stem cell infusion when a positive response to standard medical Treatment or chemotherapy has been documented. Coverage is for one transplant or infusion only within a 12-month period, unless a tandem transplant or infusion meets This Plan's definition of Covered Charges and is not an Experimental or Investigational Measure.

Cornea and skin transplants are not Covered Transplants for the purpose of this Transplant Benefits section. Instead, cornea and skin transplants are covered under the normal provisions of This Plan, and are not subject to any conditions set forth in this Transplant Benefits section.

The cost of securing an organ from a cadaver, including standard procurement charges for removal of the organ and transportation of the organ, will be considered Covered Charges.

Covered Charges will include cryopreservation and storage of bone marrow or peripheral stem cells when the cryopreservation and storage is part of a protocol of high dose chemotherapy, which has been determined by the Plan Administrator to be Medically Necessary care, not to exceed \$10,000 per approved transplant.

## 2) *Benefits Payable; Within the Transplant Network*

Benefits for Treatment received will be paid at the PPO level of benefits if the Transplant Benefits are rendered by a provider in the Transplant Network and the services are not considered to be an Experimental or Investigational Measure.

**Transplant Network** means any network of providers that the Plan Administrator determines to be an appropriate transplant network and that has contracted to provide Transplant Benefits subject to a negotiated fee schedule.

Covered Charges will also include charges incurred by the organ donor for a Covered Transplant if the charges are not covered by any other medical expense coverage. If the donor charges are incurred through a provider in the Transplant Network, Benefits Payable will be determined under this section. If the donor charges are incurred at a provider not in the Transplant Network and the Covered Person is eligible under this section, benefits for the donor charges will be limited as described under "Benefits Payable; Outside the Transplant Network."

If transplant related services are provided by a provider in the Transplant Network, travel and lodging expenses for the recipient and one companion will be covered when services are performed at a location further than the normal community patterns of care (excluding travel and lodging provided by a family member or friend). Travel and lodging benefits will be payable at 100% without application of any Deductible Amount, up to a Lifetime Benefit Maximum of \$10,000 for each approved transplant. All travel and lodging benefits must be approved in advance by Us.

## 3) *Benefits Payable; Outside the Transplant Network*

For Transplant Benefits rendered by any covered provider not in the Transplant Network, benefits will be payable on the same basis as for any other sickness up to the following maximum benefits for each surgery listed below, and up to a Lifetime Benefit Maximum of \$150,000 for each Covered Person.

(1)	Heart	\$95,000
(2)	Heart/Lung (simultaneous)	\$145,000



(3)	Lung	\$110,000
(4)	Liver	\$110,000
(5)	Kidney	\$50,000
(6)	Pancreas	\$65,000
(7)	Kidney/Pancreas (simultaneous)	\$84,000
(8)	Small Bowel	\$150,000
(9)	Bone Marrow Autologous	\$60,000
(10)	Bone Marrow Allogeneic	\$100,000

Services subject to the transplant episode and a Lifetime Benefit Maximums above will include Covered Charges as specified in this section, including but not limited to: evaluation; pre-transplant, transplant, and post-transplant care (not including out-patient immunosuppressant drugs); cadaver organ donor procurement; complications related to the procedure and follow-up care for services received during the 12 month period from the date of transplant.

The cost of securing an organ from a cadaver, including standard procurement charges for removal of the organ and transportation of the organ, will be considered Covered Charges.

The cost of organ or tissue procurement from a living person is covered if the charges are not covered by any other medical expense coverage.

Covered Charges will include cryopreservation and storage of bone marrow or peripheral stem cells when the cryopreservation and storage is part of a protocol of high dose chemotherapy, which has been determined by the Plan Administrator to be Medically Necessary care, not to exceed \$10,000 per approved transplant.

No benefits will be payable for travel and lodging expenses if services are provided outside the Transplant Network.

**4) Limitations: Applicable Within and Outside the Transplant Network**

The limitations listed in this section apply to Transplant Benefits. In addition, limitations specific to Home Health Care, Skilled Nursing Facility and Hospice provisions will apply to Transplant Benefits if those benefits are used in connection with a Covered Transplant.

For each transplant episode, Covered Charges will include:

- (1) Transplant evaluations from no more than three transplant providers; and
- (2) No more than one listing with a provider in the Transplant Network.

If the transplant is not a Covered Transplant under This Plan, all charges related to the transplant will be excluded from payment under This Plan, including but not limited to, dose-intensive chemotherapy.

Benefits will not be paid for confinement, Treatment, service or materials for:

- (1) animal-to-human organ or tissue transplants; or
- (2) any Treatment related to the use of embryonic stem cells;
- (3) implantation within the human body of artificial or mechanical devices designed to replace human organ(s); or
- (4) transportation, lodging, or any other expenses not specifically indicated as Covered Charges related to a living donor or the recipient.

**H. Transportation Benefits**

Transportation benefits apply only to Medically Necessary Treatment covered under This Plan. Transportation benefits for any foreign medical care will not be covered. Transportation benefits will not be covered for preventive care, diagnostic, or second opinion diagnosis unless services cannot be provided locally and are deemed Medically Necessary by the Cost Containment Administrator. Transportation benefits are separate from Medical and/or Prescription Drug benefits under This Plan and do not apply to any Deductible, Copayments, Co-insurance, or Out-of-Pocket levels.

If services cannot be provided locally and are deemed Medically Necessary by the Cost Containment Administrator and are provided by a Preferred Provider, travel and lodging expenses for the recipient and

one companion will be covered when services are performed at a location further than the normal community patterns of care (excluding travel and lodging provided by a family member or friend).

Travel and lodging benefits will be payable at 100% up to a Benefit Maximum of \$5,000 per Plan Year. Airfare is limited to the actual dollar cost paid for coach class commercial air transportation. Combined ground transportation and lodging will be limited to \$150 per day and will apply to the Benefit Maximum. Lodging is limited to one night before or after a single day appointment and to one night before, during, and one night after discharge for services requiring admission. All travel and lodging benefits must be approved in advance by the Cost Containment Administrator and will be paid upon submission of valid receipts and verification of services rendered.

### **I. Compliance with Federal Law**

Subject to the provisions as described above, benefits under This Plan will be payable for:

#### **1) *Newborns' and Mothers' Health Protection Act of 1996***

Under Federal law, Group Health Plans generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to fewer than 48 hours following a vaginal delivery, or fewer than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, a Group Health Plan may not, under Federal law, require that a provider obtain authorization from the Group Health Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

#### **2) *Women's Health and Cancer Rights Act of 1998***

Under Federal law, Group Health Plans and health insurance issuers providing benefits for a mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- (1) all stages of reconstruction of the breast on which the mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) Treatment of physical complications of the mastectomy, including lymphedema;

in a manner determined in consultation between the attending Physician and the patient.

These benefits are subject to all Plan provisions including the applicable Deductible, Copayments and Coinsurance based upon where and by whom services are rendered.

### **J. Limitations of Medical Benefits**

Benefits will not be paid for:

- (1) Treatment of an illness or injury except as described under Covered Charges;
- (2) Treatment that is an Experimental or Investigational Measure;
- (3) any part of a charge for Treatment that exceeds Prevailing Charges;
- (4) charges that are billed incorrectly or separately for Treatments that are an integral part of or included in another billed Treatment as determined by Us;
- (5) charges for Physician overhead, including but not limited to surgical rooms or suites or for equipment used to perform a particular Treatment (e.g., laser equipment);
- (6) Treatment for foot care with respect to: corns, calluses, trimming of toe nails, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;
- (7) Treatment for foot care with respect to: casting, testing, fitting or purchase of orthotics, or any appliance (including orthotics), except as described under Covered Charges

- (8) charges for shoes or shoe lifts;
- (9) Treatment related to the restoration of fertility or promotion of conception (infertility Treatment) except as described under Covered Charges;
- (10) molecular genetic testing for the purposes of health screening or if not part of a Treatment regimen for a specific sickness;
- (11) charges for storage of blood or blood products, unless otherwise approved by Us;
- (12) Treatment for voluntary sterilization or reversal of sterilization;
- (13) Treatment for abortion;
- (14) Treatment for contraception;
- (15) Treatment for sexual dysfunction, except when related to an illness and approved by Us;
- (16) Treatment for transsexualism;
- (17) charges incurred to improve general physical condition, including, but not limited to programs such as counseling and monitored exercise to improve or maintain general health;
- (18) Treatment for behavior modification;
- (19) Treatment for marital counseling or social counseling;
- (20) Treatment for gambling addiction, or stress management;
- (21) Treatment for educational, training or developmental problems, learning or social disorders, or instructional purposes except as described under Covered Charges;
- (22) Treatment eligible under your Dental Plan;
- (23) Dental Services except as described under Covered Charges;
- (24) Treatment for any form of temporomandibular joint disorder (TMJ) (malfunction, degeneration, or disease related to the joint that connects the jaw to the skull), including but not limited to braces, splints, appliances, or surgery of any type; unless otherwise specified under Other Covered Services in the Summary of Benefits and Coverage;
- (25) drugs and medicines eligible under the Prescription Drug Coverage for Retail Network Pharmacy and Home Delivery Pharmacy, except as listed under Covered Charges;
- (26) drugs and medicines dispensed by a Skilled Nursing Facility (Note: such drugs are eligible under the Prescription Plan if purchased at a Retail Network Pharmacy or the mail order pharmacy);
- (27) Treatment for drugs determined by the Food and Drug Administration's Drug Efficacy Study Implementation (DESI) program as lacking in substantial evidence of effectiveness;
- (28) charges for non-prescription drugs; non-prescription vitamins and minerals;
- (29) charges for nutritional supplements, special diets, special formulas;
- (30) charges for eye examinations for correction of vision or fitting of glasses, vision materials (frames or lenses) unless otherwise specified under Other Covered Services in the Summary of Benefits and Coverage;
- (31) Treatment for Kerato-Refractive Eye Surgery (surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including but not limited to radial keratotomy and keratomileusis surgery);
- (32) Treatment for Cosmetic purposes (except when the surgery results from an accidental injury and is performed within 18 months of that injury or as otherwise provided in this Summary Plan Document);

**Cosmetic** means Treatment, procedure, or surgery to change the texture or appearance of the skin; or the relative size or position of any part of the body; when such Treatment, procedure, or surgery is performed primarily for psychological purposes or is not needed to correct or improve a bodily function.

- (33) animal-to-human organ or tissue transplants; or implantation within the human body of artificial or mechanical devices designed to replace human organs;
- (34) Treatment for unattended home sleep studies without prior approval from Us;
- (35) any nursing services except as described under Covered Charges;
- (36) Treatment for Custodial Care (assistance with meeting personal needs or the activities of daily living that does not require the services of a Physician, Nurse chiropractor, physical therapist, occupational therapist, speech therapist, or other health care professional and includes bathing, dressing, getting in and out of bed, feeding, walking, elimination, and taking of medications);

**Custodial Care** means assistance with meeting personal needs or the Activities of Daily Living. For this purpose, **Activities of Daily Living** means activities that do not require the services of a Physician, Nurse, or other health care professional including, but not limited to, bathing, dressing, getting in and out of bed, feeding, walking, elimination, and taking medications.

- (37) charges for employment or immigration physicals;
- (38) Treatment for maintenance therapy or supportive care or when maximum therapeutic benefit (no further objective improvement) has been attained except as described under Covered Charges;
- (39) charges for transportation or ambulance services except as described under Covered Charges;
- (40) Durable Medical Equipment:
  - used for personal hygiene, comfort, or convenience, whether or not recommended by a Physician, including, but not limited to, air conditioners, humidifiers, diapers, underpads, bed tables, tub bench, shower chair, hoist lift, gait belts, bedpans, physical fitness equipment, stair glides, elevator, or lift;

- used for barrier free home modifications, whether or not recommended by a Physician, including, but not limited to, ramps, grab bars, or railings;
- used for non-implantable communication-assist devices, including, but not limited to, communications boards, and computers;
- which are in excess of the purchase price of the equipment; or
- which are provided during rental for repair, adjustment, or replacement of components and accessories necessary for the functioning and maintenance of covered equipment, as this is the responsibility of the DME supplier;
- (41) charges for comfort or convenience services and supplies;
- (42) charges for prone standers, motorized carts, scooters, strollers, etc.;
- (43) charges for heating pads, heating and cooling units, ice bags or cold therapy units;
- (44) charges for devices used specifically as safety items or to affect performance in sport-related activities, including but not limited to braces or orthotic devices worn for sports;
- (45) charges for hearing aids and related charges unless otherwise specified in the Summary of Benefits and Coverage ;
- (46) charges for wigs or hair prostheses;
- (47) delivery charges or taxes;
- (48) charges for missed appointments;
- (49) charges for e-mail communication or e-mail consultation;
- (50) additional charges incurred because care was provided after hours, on a Sunday, holiday or weekend day;
- (51) Weekend Admission Charges;

**Weekend Admission Charges** means room and board charges by a Hospital for the first Friday and/or Saturday of a confinement if the patient is admitted to the Hospital on one of these days, unless the confinement is for emergency Treatment; or a surgical operation is scheduled for the day or the day after the date of admission; or medical Treatment, requiring Hospital Inpatient Confinement, is scheduled for the day or the day after the date of admission.

- (52) charges for travel and lodging except as described under Organ and Tissue Transplant Benefits;
- (53) charges for which the Covered Person is not legally obligated to pay or which are for medical or dental care furnished without charge, paid for or reimbursable by or through the government of a nation, state, province, county, municipality, or other political subdivision, or any instrumentality or agency of such a government;
- (54) Treatment rendered in a Hospital owned or operated by the United States Government, either by the Hospital or a Physician/dentist employed by it (a) unless the Treatment is of an emergency nature, and (b) unless the Covered Person is not entitled to such Treatment by reason of his status as a veteran or otherwise;
- (55) Treatment for an injury or sickness which results from war, act of war, or voluntary participation in criminal activities while a Covered Person;
- (56) Treatment for an injury or sickness which arises out of or in the course of employment, and which either entitles the Covered Person to benefits under a Worker's Compensation Act or similar legislation, or would have entitled him to benefits if coverage under such a statute could have been in force on a voluntary or elective basis;
- (57) Treatment for the purpose of duplicating or replacing equipment, brace, or supply that is lost or stolen;
- (58) charges which are eligible to be paid by a previous group plan which was replaced by enrollment in the Christian Brothers Employee Benefit Trust;

- (59) Treatment provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:
  - travel, provided the travel is for a reason other than securing medical or dental care diagnosis or Treatment;
  - a business assignment by a covered Employer;
  - the Employee is employed by a covered Employer and working outside the United States; or
  - an eligible Dependent child attending school outside the United States.
- (60) the services of any person in your Immediate Family or any person in your Dependent's Immediate Family or living in your or your Dependent's residence;

**Immediate Family** means a Covered Person's husband or wife, natural or adoptive parent, child or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of grandparent or grandchild.

- (61) Treatment provided by any type of health care practitioner not otherwise provided for in This Plan;
- (62) charges in excess of 100% of the Medicare allowance for incurred expenses due to renal dialysis;
- (63) Treatment incurred after termination of coverage under This Plan; or
- (64) Services, supplies, and/or prescription drugs prescribed under any state's Death with Dignity Act.

## **K. Utilization Management Requirements**

### **1) Hospitalization**

A Hospital Admission Review by the Cost Containment Administrator is required for all Hospital Inpatient Confinements (scheduled or emergency). Your medical identification card gives you a precertification telephone number to call your Cost Containment Administrator for Hospital Admission Review.

**Hospital** means an institution that is licensed as a hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, Custodial Care facility, or training center. Hospital shall also include an Inpatient Alcohol or Drug Abuse Treatment Facility and a Birthing Center.

**Residential Treatment Facility** means a 24-hour state licensed facility that is not a hospital. **Hospital Inpatient Confinement** means any period of Treatment in a Hospital or Residential Treatment Facility in excess of 23 consecutive hours for any cause.

**Hospital Inpatient Confinement Charges** means Covered Charges by a Hospital for room, board, and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia During a Hospital Inpatient Confinement.

**Hospital Admission Review** means review by the Cost Containment Administrator of a Physician's report demonstrating the need for a Hospital Inpatient Confinement, scheduled or emergency.

**Inpatient Alcohol or Drug Abuse Treatment Facility** means an institution that:

- (1) is licensed by the proper authority of the state in which it is located; and
- (2) is primarily engaged in providing alcohol or drug detoxification or rehabilitation Treatment services; and
- (3) is supervised on a full-time basis by a Doctor of Medicine or Doctor of Osteopathy; and
- (4) provides 24-hour a day on-site nursing care by a Nurse.

The Physician's report (verbal or written) must include: the reasons for the Hospital Inpatient Confinement; significant symptoms, physical findings, and Treatment plan; procedures performed or to be performed during the Hospital Inpatient Confinement; and estimated length of the Hospital Inpatient Confinement.

Notification of the number of Hospital days authorized will be sent to you, your Physician, and the Hospital. If you or your Physician has any

questions, please call the toll-free number of the Cost Containment Administrator.

The benefits payable for Hospital Inpatient Confinement Charges will be reduced 25% up to \$2,000 per Calendar Year unless:

- (1) For Hospital Inpatient Confinement Charges, a Hospital Admission Review is requested from the Cost Containment Administrator by you, a Dependent, or a designated patient representative as soon as a Hospital Inpatient Confinement is scheduled, but no later than the day of a Hospital Inpatient Confinement, for other than a Medical Emergency; and for a Medical Emergency within two business days of a Hospital Inpatient Confinement; and
- (2) If a Hospital Admission Review is not requested in a timely manner as specified above, a reduction in benefits payable will be applied to all Hospital Inpatient Confinement Charges, but only to the charges incurred up to the date a Hospital Admission Review is obtained.

If a Hospital Inpatient Confinement exceeds the approved number of days, the Cost Containment Administrator will initiate a Continued Stay Review. A Continued Stay Review means a review by the Cost Containment Administrator of a Physician's report of the need for continued Hospital Inpatient Confinement.

Benefits will be payable only for that part of the Hospital Inpatient Confinement Charges the Cost Containment Administrator determines to be Medically Necessary.

The following exception applies to Hospital Inpatient Confinement for childbirth.

Hospital Admission Review is not required for mother and baby for:

- (1) A 48-hour Hospital Inpatient Confinement following vaginal delivery; or
- (2) A 96-hour Hospital Inpatient Confinement following cesarean section.

A request for review by the Cost Containment Administrator of the need for continued Hospital Inpatient Confinement for mother or baby beyond the automatically approved time period stated above must be made by a designated patient representative before the end of that time period.

If you, a Dependent, or a designated patient representative fail to request a Hospital Admission Review as specified in this section, benefits will be reduced as described above for all Hospital Inpatient Confinement Charges incurred beyond the 48-hour or 96-hour automatically approved Hospital Inpatient Confinement for childbirth. No benefits will be payable for any Treatment that is not for Medically Necessary Care.

The reduction in benefits payable is a penalty for failure to comply with the Utilization Management Requirements listed. The reduction:

- (1) of 25% will not count toward satisfaction of the Out-of-Pocket Expense Maximum(s); and
- (2) will not exceed \$2,000 per Plan Year for any one person

### **2) Outpatient Diagnostic Imaging**

An Outpatient Diagnostic Imaging Review by the Cost Containment Administrator is required for all Outpatient Diagnostic Imaging. Your medical identification card gives you a Precertification telephone number to call your Cost Containment Administrator for Diagnostic Imaging Review.

Diagnostic Imaging Review means review by the Cost Containment Administrator of a Physician's report demonstrating the need for the Diagnostic Imaging.

Outpatient Diagnostic Imaging includes, but is not limited to, MRI, MRA, PET, CT and SPECT imaging tests.

Benefits payable for Outpatient Diagnostic Imaging will be reduced by 25% unless:

- (1) an Outpatient Diagnostic Imaging review is requested by you, or a family member, or a Physician and approved by the Cost Containment Administrator.
- (2) services beyond the original approval, the Outpatient Diagnostic Imaging review is extended and approved by the Cost Containment Administrator.

The request must be prior to, but no later than, the day of testing by an Outpatient Diagnostic Office or Facility (for other than a Medical Emergency).

Notification of authorization will be sent to you, your Physician, and the Outpatient Diagnostic Office or Facility. If you or your Physician has any questions, please call the toll-free number of the Cost Containment Administrator.

If an Outpatient Diagnostic Imaging review is not requested prior to testing as specified above, the 25% reduction in benefits payable will be applied. Benefits will be payable only for that part of the Outpatient Diagnostic Imaging charges that have been approved by the Cost Containment Administrator and that We determine to be Covered Charges.

The 25% reduction in benefits payable is a penalty for failure to comply with the Utilization Management Requirements listed. The reduction:

- (1) will not count toward satisfaction of the Out-of-Pocket Expense Maximum(s); and
- (2) will not exceed \$300 per occurrence for any one person.

### **3) Outpatient Surgery**

An Outpatient Surgery Review by the Cost Containment Administrator is required for all Outpatient Surgery. Your medical identification card gives you a Precertification telephone number to call your Cost Containment Administrator for Surgery Review.

Outpatient Surgery Review means review by the Cost Containment Administrator of a Physician's report demonstrating the need for the Surgery.

The Physician's report (verbal or written) must include: the reasons for the Surgery; significant symptoms, physical findings, and Treatment plan; and procedures performed or to be performed during the Surgery.

Notification of authorization will be sent to you, your Physician, and the Hospital or Outpatient Facility. If you or your Physician has any questions, please call the toll-free number of the Cost Containment Administrator.

Benefits will be payable only for that part of the Surgery the Cost Containment Administrator determines to be Medically Necessary.

Benefits payable for Outpatient Surgery will be reduced by 25% unless:

- (1) an Outpatient Surgery Review is requested by you, or a family member, or a Physician and approved by the Cost Containment Administrator, and;
- (2) services beyond the original approval, the Outpatient Surgery review is extended and approved by the Cost Containment Administrator.

The request must be prior to, but no later than, the day of surgery by a Hospital or Outpatient Facility (for other than a Medical Emergency).

If an Outpatient Surgery review is not requested prior to surgery as specified above, the 25% reduction in benefits payable will be applied. Benefits will be payable only for that part of the Outpatient Surgery charges that have been approved by the Cost Containment Administrator and that We determine to be Covered Charges.

The 25% reduction in benefits payable is a penalty for failure to comply with the Utilization Management Requirements listed. The reduction:

- (1) will not count toward satisfaction of the Out-of-Pocket Expense Maximum(s); and
- (2) will not exceed \$300 per occurrence for any one person.

## L. Notice of Utilization Review

For purposes of satisfying the claims processing requirements, receipt of a claim will be considered to be met when Notification of Utilization Review is received by Us or the Cost Containment Administrator.

**Notification of Utilization Review** means receipt of necessary information to initiate review of a request for Utilization Review services to include the patient's name and your name (if different from patient's name), attending Physician's name, treating facility's name, diagnosis, and date of service.

**Utilization Review** means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities.

**Initial Clinical Review** means a clinical review conducted by appropriate licensed or certified health professionals. Initial Clinical Review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to a Peer Clinical Reviewer for certification or Noncertification. The person conducting the Initial Clinical Review is called the **Initial Clinical Reviewer**.

**Peer Clinical Review** means a clinical review conducted by a Physician or other health professional when a request for an admission, procedure, or service was not approved during the Initial Clinical Review. The person conducting the Peer Clinical Review is called the **Peer Clinical Reviewer**. In the case of an appeal, the Peer Clinical Reviewer is a Physician or other health professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition procedures, or Treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the ordering provider.

**Noncertification** means a decision by the Cost Containment Administrator that an admission, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the Cost Containment Administrator's requirements for



Medically Necessary care, appropriateness, health care setting level of care or effectiveness, and the request is therefore denied, reduced, or terminated.

If the Covered Person, or designated patient representative fails to follow the Cost Containment Administrator's procedures for filing a claim for Hospital Admission Review, a Prospective Review or an Urgent Review, the Cost Containment Administrator will notify the Covered Person or designated patient representative of the failure and the proper procedures to be followed.

For certification, the Cost Containment Administrator will provide notification to the attending Physician, the facility rendering service, and you or the patient. Upon request, the Cost Containment Administrator will provide written notification of the certification. For Noncertifications, notification will be made in writing to the attending Physician, the facility rendering service, and you or the patient.

### *1) Prospective Review*

**Prospective Review** means a Utilization Review conducted prior to a patient's stay in a Hospital or other health care facility or course of Treatment including any required preauthorization or precertification.

For an initial Prospective Review, a decision and notification of the decision will be made within 15 days of the date the Notification of Utilization Review is received by Us or the Cost Containment Administrator. If a decision cannot be made due to insufficient information, the Cost Containment Administrator will either issue a Noncertification or send an explanation of the information needed to complete the review prior to expiration of the 15 days. If the Cost Containment Administrator does not issue a Noncertification and requests additional information to complete the review, you, the patient, the attending Physician, or the facility rendering the service is permitted up to 45 days to provide the necessary information. The Cost Containment Administrator will render a decision within 15 days of either receiving the necessary information or, if no additional information is received, upon the expiration of 45 days.

### *2) Urgent Prospective Review*

**Urgent Prospective Review** means a Utilization Review that must be completed sooner than a Prospective Review in order to prevent serious jeopardy to your or the patient's life or health or the ability to regain maximum function, or in the opinion of a Physician with knowledge of you or the patient's medical condition, would subject you or the patient to severe pain that cannot be adequately managed without Treatment. Whether or not there is a need for an Urgent Prospective Review is based upon the Cost Containment Administrator's decision using the judgment of a prudent lay-person who possesses an average knowledge of health and medicine

For Urgent Prospective Review, a decision and notification of the decision will be made within 24 hours of the date the Notification of Utilization Review is received by Us or the Cost Containment Administrator. If a decision cannot be made due to insufficient information, the Cost Containment Administrator will either issue a Noncertification or send an explanation of the information needed to complete the review within 24 hours of receipt of Notification of Utilization Review Services. If the Cost Containment Administrator does not issue a Noncertification and requests additional information to complete the review, you, the patient, the attending Physician, or the facility rendering the service is permitted up to 48 hours to provide the necessary information. The Cost Containment Administrator will render a decision within 48 hours of either receiving the necessary information or, if no additional information is received, upon the expiration of the 48 hours.

### *3) Concurrent Review*

**Concurrent Review** means a Utilization Review conducted during a patient's Hospital stay or course of Treatment.

For a Concurrent Review that does not involve an Urgent Concurrent Review, a request to extend a course of Treatment beyond the period of time or number of Treatments previously approved by Us or the Cost Containment Administrator will be decided within the timeframes and according to the requirements for Prospective Review.

For an Urgent Concurrent Review, a request to extend a course of Treatment beyond the period of time or number of Treatments previously approved by Us or the Cost Containment Administrator will be decided and notification of the decision will be made within 24 hours of receipt of the Notification of Utilization Review Services if the request is made at least 24 hours prior to the expiration of the previously approved period or number of Treatments. If a request is made fewer than 24 hours prior to the expiration of the previously approved period of number of Treatments, a decision and notification of the decision will be made within 72 hours of receipt of the Notification of Utilization Review Services.

#### **4) Retrospective Review**

**Retrospective Review** means a Utilization Review conducted after the patient is discharged from a Hospital or other health care facility or has completed a course of Treatment.

For a Retrospective Review, a decision and notification of the decision will be made within 30 days after the date the Notification of Utilization Review is received by Us or the Cost Containment Administrator. If a decision cannot be made due to insufficient information, the Cost Containment Administrator will either issue a Noncertification or send an explanation of the information needed to complete the review prior to the expiration of the 30 days. If the Cost Containment Administrator does not issue a Noncertification and requests additional information to complete the review, you, the patient, the attending Physician, or the facility rendering the service is permitted up to 45 days to provide the necessary information. The Cost Containment Administrator will render a decision within 15 days of either receiving the necessary information or, if no additional information is received, upon the expiration of 45 days.

#### **5) Request for Reconsideration**

When an initial decision is made not to certify an admission or other service and no peer-to-peer conversation has occurred, upon the request of the attending Physician, the Peer Clinical Reviewer that made the initial decision will be made available within one business day to

discuss the Noncertification decision with the attending Physician. If the original Peer Clinical Reviewer is not available, another Peer Clinical Reviewer will be made available to discuss the review.

At the time of the conversation, if the reconsideration process is unable to resolve the difference of opinion regarding a decision not to certify, the attending Physician will be informed of his or her right to initiate an appeal and the procedure to do so.

#### **6) Expedited Appeal Review and Voluntary Appeal Review**

An **Expedited Appeal Review** means a request, usually by telephone but can be written, for a review of a decision not to certify an Urgent Review. An Expedited Appeal Review must be requested within 180 days of the receipt of a Noncertification. A decision and notification of the decision on the Expedited Appeal Review of an Urgent Review decision will be made within 72 hours from request of an Expedited Appeal Review. Written or electronic notification of the appeal review outcome will be made to the attending Physician and you or the patient.

If the Noncertification is affirmed on the appeal review, you, the patient, or attending Physician can request a voluntary appeal. The appeal may be requested by telephone, or in writing. You, the patient or the attending Physician may submit written comments, documents, records, and other information relating to the request for appeal. An independent review agency will make a decision within 30 days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, the independent review agency will send a written explanation of the additional information that is required or an authorization for you or the patient's signature so information can be obtained from the attending Physician. This information must be sent to the independent review agency within 45 days of the date of the written request for information. Failure to comply with the request for additional information could result in declination of the appeal. A decision will be made and notification of the outcome will be provided within 30 days of the receipt of all necessary information to properly review the appeal request.

**NOTE: THE EXPEDITED APPEAL REVIEW DOES NOT APPLY TO RETROSPECTIVE REVIEWS.**

**7) Standard Appeal Review and Voluntary Appeal Review**

A standard appeal may be requested either in writing or verbally. It must be requested within 180 days of the receipt of a Noncertification.

A decision and notification of the decision will be made in writing to you or the patient and the attending Physician within two business days (but no later than 30 days from receiving the request for an appeal review.)

If the Noncertification is affirmed on the appeal review, you, the patient, or attending Physician can request a voluntary appeal. The appeal may be requested by telephone, or in writing. You, the patient or the attending Physician may submit written comments, documents, records, and other information relating to the request for appeal. A determination will be made by an independent review agency within 30 days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, the independent review agency will send a written explanation of the additional information that is required or an authorization for you or the patient's signature so information can be obtained from the attending Physician. This information must be sent to the independent review agency within 45 days of the date of the written request for information. Failure to comply with the request for additional information could result in declination of the appeal. A decision will be made and notification of the outcome will be provided within 30 days of the receipt of all necessary information to properly review the appeal request.

**M. Medical Claim Procedures**

**1) Claim Forms**

Special claim forms are not required to file a claim with Us. Standard industry computerized forms may be used by your providers to submit a claim. When you become covered, you will be issued an identification card. This card should be presented to each provider at the time a Cov-

ered Person receives needed medical care. The Cost Containment Administrator will assist you with the Hospital Precertification Authorization in accordance with the terms of your coverage under This Plan.

All Claims Must Be Received By Us Within One Year From The Date of Service To Be Eligible For Benefit Consideration.

Proof of loss sent later will be accepted only if there is reasonable cause for the delay and if the claim is received no later than two years after date of service.

For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when We receive proof of claim. Proof of claim includes the patient's name, your name (if different from the patient's name) and identification number, patient's date of birth, provider of services, dates of services, diagnosis, description of Treatment provided, and the amount of claim. We may request additional information to substantiate your loss or require a signed unaltered authorization to obtain information from the provider. Your failure to comply with such request could result in your claim being declined.

**2) Payment and Denial**

We will process your claim as quickly as possible after We have received all the required information, but no later than 30 days after receipt of the claim and all supporting documentation.

If We cannot render a decision within 30 days because you have not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under This Plan, the denial notice will describe the specific information needed to complete the claim. You will have 45 days from receipt of the notice to provide the required information. We will then have 30 days from the date of receiving your information to render Our decision.

**3) Independent Medical Examinations**

We may have the Covered Person for whom the claim is made examined by a Physician. We will pay for these examinations and will choose the Physician to perform them.

#### 4) Release of Medical Information

As a condition of receiving benefits under This Plan, you and your Dependents authorize:

- (1) any provider to disclose to Us any medical information We request;
- (2) Us to examine your medical records at the office of any provider;
- (3) Us to release to or obtain from any person or organization any information necessary to administer your benefits; and
- (4) Us to examine your employment records in order to verify your eligibility.

#### 5) Form and Content of Notice of Adverse Benefit Determinations

If an adverse benefit determination is made, including a denial of a claim in whole or in part, or a rescission of coverage, notice of such adverse determination will be provided to you. Notice will be written in either paper or electronic format; oral notice might be provided only with respect to urgent care claims, but only if written confirmation is furnished to you within 3 days after the oral notice is provided.

The notice will include the following:

- (1) the specific reason or reasons for the adverse determination, including the denial code, the meaning of the code and the standard, if any, used in denying the claim;
- (2) reference to the specific Plan provisions on which the determination is based;
- (3) if applicable, a description of any additional information needed for you to perfect the claim and an explanation of why such information is needed;
- (4) a description of This Plan's review procedures, including a statement of your right to an external review;

- (5) a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;
- (6) if the adverse determination is based on Medical Necessity, Experimental or Investigational Measure or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of This Plan to your medical circumstances, or a statement that this will be provided without charge upon request;
- (7) in the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims;
- (8) information sufficient to identify the claim involved, including the date of service, the healthcare provider, the claim amount, the diagnosis code, the Treatment code and the corresponding meanings of these codes; and
- (9) information about the availability of, and contact information for, any applicable office of health insurance consumer assistance that can assist you with internal claim appeals and external review processes.

#### N. Right of Recovery

If it is determined that benefits paid under This Plan should have been paid by any other plan, We will have the right to recover those payments from:

- (1) the person to or for whom the benefits were paid; and/or
- (2) the other companies or organizations liable for the benefit payments.

To the extent permitted by law, the rights of any Covered Person under This Plan may not be voluntarily or involuntarily transferred or assigned; provided, however, that all benefits of a Covered Person shall be paid to the permitted providers of care except to the extent that the

Covered Person submits a provider statement showing that the Covered Person has paid the provider all or a portion of the covered expenses for which benefits are payable under This Plan.

### **1) Assignment of Benefits**

This Plan will use its best efforts to recognize assignments of benefits from providers of services but is not bound by such assignments. Notwithstanding the foregoing, This Plan will not recognize any assignment of a Covered Person's right to bring a cause of action or otherwise initiate a legal proceeding arising from an adverse benefit determination. When payment is made directly to the Covered Person (with or without an assignment), it is solely the responsibility of the Covered Person to reimburse the provider.

### **2) Applicability**

Where allowed by law, this section will apply to Covered Persons who:

- (1) receive benefit payment under This Plan as the result of a sickness or injury; and
- (2) have a lawful claim against another party or parties for compensation, damages, or other payment for the same sickness or injury; and
- (3) recover payment from such party or parties which includes an amount (or part of an amount) previously paid under This Plan for Treatment.

### **3) Transfer of Rights**

In those instances where this section applies, the rights of the Covered Person to claim or receive compensation, damages, or other payment from the other party or parties will be transferred to the Trust, but only to the extent of benefit payments made under This Plan.

## **O. Medical Appeal Procedures**

### **1) Internal Appeal**

You or your authorized representative may request an appeal in writing of an adverse benefit determination, a claim denied in whole or in part,

within 180 days of receipt of notice of the adverse benefit determination. Any such written request for review must state the reason or reasons why you believe that the original decision was incorrect.

If more information is needed, We will send a written request for the additional information. You, the patient, the attending Physician, or the facility rendering the service is permitted up to 45 days to provide the necessary information. Failure to receive the additional information could result in your appeal being denied. A determination will be made and notification of the outcome will be provided within 30 days of the receipt of all necessary information to properly review the appeal request. During the appeal:

- (1) you will be given reasonable access to, and copies of, all documents relevant to the claim, free of charge;
- (2) you will be permitted to review the claim file and present evidence and testimony;
- (3) if any new or additional evidence is considered, relied upon, or generated by This Plan or if Our decision is based on a new rationale, then We will provide you, upon request, with such evidence or rationale sufficiently in advance of the date by which We are required to decide the final appeal in order to provide you with reasonable opportunity to respond prior to such date;
- (4) you may submit documents, issues and comments in writing and such material will be considered on review without regard to whether it was considered in the original benefit determination;
- (5) if the denial was based on a medical judgment, you have the right to have your claim reviewed by a health care professional with appropriate training and experience in the applicable field who was not consulted during the initial benefit determination;
- (6) you shall have the right to have identified to you the experts whose advice was obtained in connection with the initial adverse benefit determination, even if the advice was not relied on;

- (7) if We fail to strictly adhere to all the requirements of the internal claim and appeal procedures set forth above, you will be deemed to have exhausted the internal claim and appeal procedures and may initiate an external review and pursue any remedies available under applicable law.

The review of a claim denial during the internal appeal will be conducted by a Plan fiduciary who will not be the individual who made the initial adverse benefit determination, nor the subordinate of such individual. This fiduciary will not give deference to the initial claim denial or initial appeal decision.

If your claim is denied during the appeal process, in whole or in part, the written notice will include:

- (1) the specific reason or reasons for the adverse determination, including the denial code, the meaning of this code, the standard, if any, used in denying the claim and a discussion of the decision;
- (2) reference to the specific Plan provisions on which the determination is based;
- (3) a statement that you are entitled to receive without charge reasonable access to any document:
  - relied on in making the determination;
  - submitted, considered or generated in the course of making the benefit determination;
  - that demonstrates compliance with the administrative processes and safeguards required in making the determination; or
  - constitutes a statement of policy or guidance with respect to This Plan concerning the denied Treatment without regard to whether the statement was relied on;
- (4) a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;

- (5) if the adverse determination is based on Medical Necessity, Experimental or Investigational Measure or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of This Plan to your medical circumstances, or a statement that this will be provided without charge upon request;
- (6) information sufficient to identify the claim involved, including the date of service, the provider, the claim amount, the diagnosis code, the Treatment code, and the corresponding meanings of these codes; and
- (7) information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist you with internal claims and appeals and external review processes.

## *2) External Appeal*

You or your authorized representative, may request a review of an adverse benefit determination by making written request to This Plan Administrator, within 4 months of receipt of notification of the final internal denial of benefits.

You may request an expedited external review upon your receipt of either of the following:

- (1) a denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize your health or life or your ability to regain maximum function and you have filed an internal appeal request; or
- (2) a final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your health or life or your ability to regain maximum function or if the final determination involves any of the following:

- an admission,
- availability of care,
- continued stay, or
- a health care item or service for which you received Emergency services, but have not been discharged from a facility.

### 3) *Right to External Appeal*

Within 5 business days of receipt of the request (or immediately after receiving your request for expedited external review), We will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that:

- (1) you are or were covered under This Plan at the time the health care item or service was requested or, in the case of a Retrospective Review, were covered under This Plan at the time the health care item or service was provided;
- (2) the final internal denial does not relate to your failure to meet Plan eligibility requirements;
- (3) you have exhausted This Plan's appeal process, to the extent required by law; and
- (4) you have provided all of the information and forms required to complete an external review.

### 4) *Notice of Right to External Appeal*

We (or Our designee) shall provide you or your authorized representative with a written notice of the decision as to whether the claim is eligible for external review within 1 business day after completion of the preliminary review (or immediately in the case of an expedited external review request).

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

- (1) the reason for ineligibility and the availability of the Employee Benefits Security Administration, if the request is complete but not eligible for external review; and

- (2) if the request is incomplete, the information or materials necessary to make the request complete and the opportunity for you to perfect the external review request by the later of the following:

- the end of the 4 month filing period; or
- within the 48 hour time period following your receipt of notification.

### 5) *Independent Review Organization*

An Independent Review Organization (IRO) that is accredited by URAC or a similar nationally recognized accrediting organization shall be assigned to conduct the external review. The assigned IRO will notify you timely, in writing, of the request's eligibility and acceptance for external review. At that time, the IRO will notify you of the right to provide additional information for consideration. In addition, This Plan will provide the IRO with the documents and information considered in the claim or appeal denial.

The IRO will review all of the information and documents received timely. In reaching its decision, the IRO will not be bound by any decisions or conclusions reached during This Plan's internal claim and appeal process. The IRO will utilize legal experts where appropriate to make coverage determinations under This Plan. In addition to the documents and information provided by you or your representative and This Plan, the IRO may consider the following information in reaching a decision to the extent it is available and appropriate:

- (1) your medical records;
- (2) the attending healthcare professional's recommendation;
- (3) consulting reports from appropriate health care professionals and other documents submitted by the health carrier, Covered Person, the Covered Person's authorized representative, or the covered person's treating Physician or health care professional;
- (4) the terms of This Plan;

- (5) appropriate practice guidelines, including applicable evidence-based standards; and
- (6) the opinion of the IRO's clinical reviewers after considering the relevant information described above.

**6) Notice of External Review Determination**

The assigned IRO shall provide Us (or Our designee) and you (or your authorized representative) with a written notice of the final external review decision within 45 days after receipt of the external review request. In the case of an expedited external review, the assigned IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after receipt of the expedited external review request. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide Us (or Our designee) and you (or your authorized representative) written confirmation of its decision within 48 hours after the date of providing that notice.

The written notice of the decision on external review shall include the following:

- (1) a general description of the reason for the external review request, including information identifying the Claim, including the date or dates of service, the provider, the Claim amount, the diagnosis code and its meaning, the Treatment code and its meaning and the reasons for the previous denial;
- (2) the date the IRO received the assignment to conduct the external review and the date of the IRO's decision;
- (3) the evidence or documentation the IRO considered in reaching its decision;
- (4) the principal reason or reasons for the IRO's decision, including its rationale and any evidence-based standards that were relied upon in making the decision;
- (5) a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Group Health Plan or to You;

- (6) a statement that judicial review may be available to you; and
- (7) current contact information, including a phone number, for any applicable office health insurance consumer assistance or ombudsman.

The Notice of Final External Review Decision from the IRO is binding on you, This Plan and Plan Administrator, except to the extent that there may be other remedies available under State or Federal law.

If the IRO reversed the claim or appeal denial, This Plan must immediately provide you coverage or payment for the claim.

**7) Assignment**

No Covered Person may assign to a provider his or her right to file an appeal or to file a suit for benefits. As the sole exception to this prohibition, a Covered Person may assign his right to appeal to a medical provider if the appeal involves an Urgent Review.

**P. Coordination with Other Benefits – Medical**

The intent of this Coordination with Other Benefits section is to provide that the sum of benefits paid under This Plan (except the benefits provided under the Prescription Drug Benefits) plus benefits paid under all other Plans will not exceed the actual cost charged for a Treatment.

**1) When Coordination Applies**

If a Covered Person is covered under more than one plan, This Plan will coordinate benefits with the other plan or plans. This means that the total payment from all plans will not exceed 100% of Allowable Expenses.

**This Plan** means the medical, dental, and vision benefits described in this Summary Plan Document.

**Another Plan** means any of the following insurance or group-type insurance coverage, whether insured or self-insured, that provides benefits or services for Hospital, medical, mental health and substance use disorders, prescription drug, hearing, dental or vision care Treatment:



- (1) Insurance coverage other than school accident type coverage;
- (2) Coverage through HMOs and other prepayment, group practice and individual practice plans;
- (3) The medical benefits coverage in group, group-type and individual automobile no fault and traditional automobile fault type contracts; or
- (4) A governmental plan, including Medicare as provided under the Social Security Act and coverage required or provided by law but not Medicaid.

The term Allowable Expenses will mean all Prevailing Charges for Treatment when at least a part of those charges are covered under at least one of This Plans then in force for the person for whom benefits are claimed.

## 2) *Benefits Payable under Coordination*

**Claim Determination Period** means the part of a Plan Year during which a Covered Person would receive benefit payments under This Plan if this section were not in force.

Benefits otherwise payable under This Plan for Allowable Expenses during a Claim Determination Period may be reduced if:

- (1) benefits are payable under Another Plan for the same Allowable Expenses; and
- (2) the rules listed below provide that benefits payable under Another Plan are to be determined before the benefits payable under This Plan.

The reduction will be the amount needed to provide that the sum of payments under This Plan plus benefits payable under Another Plan is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately; such reduced amount will be charged against any applicable benefit limit of This Plan.

## 3) *Order of Benefit Determination*

Except as described under Medicare Exception below, the benefits payable of Another Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of Another Plan that does have such a provision. In all other instances, the order of determination will be in the order set forth below:

- (1) If Another Plan does not have a provision for the coordination of benefits, its benefits are payable before This Plan.
- (2) If Another Plan covers a person other than as a Dependent, its benefits are payable before This Plan. This includes Medicare covering a person other than as a Dependent (e.g., a retired Employee) and any Medicare Supplement Plan. However, in all instances, federal regulations regarding Medicare as a secondary payer will apply.
- (3) If Another Plan covers an active Employee, its benefits are payable before This Plan. This order of determination does not supersede No. 2 above.
- (4) If an individual is covered as a Dependent under two separate plans, the benefits are payable first under the Employee's plan having the earliest birthday in a Calendar Year. However, if the Dependent is a child whose parents are separated or divorced, the birthday rule does not apply. The following order of determination will apply:
  - (a) If the parent with custody has not remarried:
    - The plan of the parent with custody is primary.
    - The plan of the parent without custody is secondary.
  - (b) If the parent with custody has remarried:
    - The plan of the parent with custody is primary.
    - The plan of the stepparent with custody is secondary.

- The plan of the parent without custody is third.

If there is a court order that makes one parent financially responsible for the health care expenses incurred by the child, then, if a plan covers the child as a Dependent of that parent, its benefits are payable before those of a plan that covers the child as a Dependent of the parent without financial responsibility.

Benefits available for a newborn child under Another Plan for which a Covered Person is eligible, will be determined before benefits under the Automatic Coverage for a Newborn Child provision of This Plan.

If the above items do not apply, the benefits of a plan that has covered the person for the longest period of time will be payable before those of the other plan.

#### **4) *Coordination with HMOs***

If a Covered Dependent is covered under an HMO and, pursuant to the terms set forth above, HMO must provide benefits before This Plan, the Dependent is required to access benefits available under the HMO.

If the Covered Dependent does not access benefits available under the HMO, This Plan will only consider 50% of This Plan's Covered Charges applicable to such Covered Dependent.

#### **5) *Coordination with Excess Only or Secondary Only Plans***

If a Covered Person is covered by Another Plan containing a provision, either excess only or secondary only of other available benefits This Plan will be prorated between This Plan and Another Plan on an equal basis.

#### **6) *Integration With Medicare***

(For all Covered Persons where permitted by Law)

The payments under This Plan are reduced by the benefits available under Medicare.

Note: Any balance owed to a provider after Medicare payment may not be paid by This Plan unless your Out-of-Pocket Expense Maximum has been reached for the year.

It works this way:

- (1) In determining a claim payment under This Plan, the first step is to calculate the amount that would be paid if the person had no Medicare coverage. The Covered Charges under This Plan will be limited to the amounts approved by Medicare or no more than the limiting charges as determined by Medicare.
- (2) The above amount is reduced by the Medicare benefits for the expenses upon which the claim under This Plan is based. In determining the Medicare benefits, the person will be assumed to have full Medicare coverage (that is, both Part A and Part B) whether or not the person has enrolled for the full coverage.
- (3) If a provider has chosen not to apply to Medicare to become a participating provider, This Plan will estimate Medicare benefits as if application has been made and was approved. Any benefit payable by This Plan will then be calculated as if Medicare had been paid.

If Medicare benefits are paid for expenses not covered under This Plan, they will not be used to reduce our benefits. In the case of services and supplies for which Medicare makes direct reimbursement to the provider, the amount of expenses and Medicare benefits will be determined on the basis of the Prevailing Charges for the services and supplies.

#### **7) *Exchange of Information***

Any person who claims benefits under This Plan must, upon request, provide all information We believe is needed to coordinate benefits.

In addition, all information We believe is needed to coordinate benefits may be exchanged with other companies, organizations, or persons with whom we are coordinating benefits.

## 8) Facility of Payment

We may reimburse any other plan if:

- (1) benefits were paid by that other plan; but
- (2) should have been paid under This Plan in accordance with this section.

In such instances, the reimbursement amounts will be considered benefits paid under This Plan and, to the extent of those amounts, will discharge Us from liability.

## 9) Reimbursement/Subrogation

If This Plan provides any benefits in connection with a Claim by a Covered Person, the Covered Person shall reimburse This Plan, to the extent of all amounts that This Plan has paid, from any amounts that the Covered Person recovers from any source other than This Plan in connection with the Claim. The Covered Person's recovery from a source other than This Plan shall not be reduced by the amount of the Covered Person's attorney fees or for any other reason whatsoever, until This Plan has been repaid in full.

In addition, This Plan shall be subrogated to any legal rights which the Covered Person may have to recover against any party in connection with the Claim.

This reimbursement/subrogation provision applies to recoveries available to minor children from sources other than This Plan.

By accepting benefits under This Plan, the Covered Person hereby grants a lien and assigns to This Plan an amount equal to the benefits paid against any recovery made by or on behalf of the Covered Person. The assignment is binding on any attorney who represents the Covered Person whether or not an agent of the Covered Person and on any insurance company or other financially responsible party against whom a Covered Person may have a claim provided said attorney, insurance carriers or others have been notified by This Plan or its agents.

## 5. PRESCRIPTION DRUG COVERAGE

### A. Description of Benefits

#### 1) Retail Network Pharmacy

If drugs and medicines are prescribed to treat a Covered Person, We will pay Retail Network Pharmacy benefits for Covered Charges:

- (1) in excess of the Copayment, if applicable;
- (2) in excess of the Deductible, if applicable; and
- (3) at the payment percentage indicated;

as described in the Summary of Benefits and Coverage.

Benefit payments will be restricted to:

- (1) Covered Charges as described below; and
- (2) up to a 30 day supply for each prescription and each refill at a Retail Network Pharmacy.

#### 2) Mail Order Pharmacy

If maintenance drugs and medicines are prescribed to treat a Covered Person, We will pay mail order prescription benefits for charges:

- (1) in excess of the Copayment, if applicable;
- (2) in excess of the Deductible, if applicable; and
- (3) at the payment percentage indicated;

as described in your Summary Benefits and Coverage.

Maintenance Drugs are those taken on a regular or long term basis to treat such conditions as high blood pressure, ulcers, arthritis, heart or thyroid conditions, emphysema or diabetes, etc.

Benefit Payment will be restricted to:

- (1) prescribed Maintenance Drugs which are necessary to treat a chronic or long term sickness or injury; and
- (2) up to a 90 day supply for each prescription and each refill; and

- (3) prescriptions which are filled through the pharmacy designated to administer the mail order prescription drug program.

## B. Your Formulary

Your prescription drug plan includes a Formulary. **Formulary** means a list of drugs that are preferred by This Plan. This list includes a wide selection of drugs and is preferred because it offers you a choice while helping to keep the cost of your prescription drug benefits affordable. Each drug is approved by the Food and Drug Administration and reviewed by an independent group of doctors and pharmacists for safety and effectiveness. The Plan's Formulary is provided by the Pharmacy Benefits Manager. The Formulary is subject to change from time to time. In the event that your medication is removed from the Formulary, you will be notified well in advance and informed of other drugs available to you in the same therapeutic class. Medications not on the Formulary are not covered by This Plan.

The Pharmacy Benefits Manager may remind your doctor when a Formulary medication is available as a possible alternative for a drug that is not on your Formulary. This may result in a change in your prescription. However, your doctor will always make the final decision on your medication.

**NOTE: TO VERIFY IF A DRUG IS CONSIDERED A FORMULARY MEDICATION OR A LONG-TERM MAINTENANCE PRESCRIPTION DRUG, CONTACT THE PHARMACY BENEFITS MANAGER.**

## C. Covered Charges

Covered Charges will be the actual cost charged to Covered Person for:

- (1) Federal Legend Drugs, including vitamins and minerals, which may be legally dispensed only upon the written prescription of a Physician; and
- (2) Insulin and supplies for injection of insulin.

## D. Payment of Prescription Drug Benefits

If you buy your prescription drugs from a Retail Network Pharmacy, you should:

- (1) present your identification card to the pharmacist with your prescription each time you need to have a prescription filled or refilled;
- (2) sign the pharmacy claims voucher (the pharmacist will have this voucher); and
- (3) pay the pharmacist the applicable payment amount as described in the Summary of Benefits and Coverage.

If you buy your prescription drugs from a non-network pharmacy, you should:

- (1) pay the pharmacist the entire cost of the prescription;
- (2) call the Pharmacy Benefits Manager at the telephone number listed on your identification card to obtain a special claim form; and
- (3) complete the claim form, include your prescription receipt, and mail the completed form and receipt to the address shown on the form. Although reduced benefits are payable because you used a non-network Pharmacy, the appropriate prescription drug benefits will be paid directly to you.

## E. Prescription Drug Management

For certain drugs and classes of drugs as designated by Us, We reserve the right to:

- (1) require Prior Authorization for dispensing;
- (2) limit payment of benefits to specified quantities, Drug Quantity Management;
- (3) require the dispensing of certain drugs before paying benefits for another drug within a given class, as established by Us, Step Therapy;
- (4) set Deductible, Copayments, or Coinsurance levels for certain Non-Essential medications up to any available

foundational or manufacturer sponsored patient assistance program; and

**Non-Essential Benefits** are benefits that do not qualify as Minimum Essential Benefits as outlined by the Patient Protection and Affordable Care Act of 2010 and further defined by Health & Human Services regulations.

- (5) limit the number of fills that may be obtained through retail pharmacies.

You may call the Pharmacy Benefits Manager directly at the telephone number listed on your identification card to verify specific drug coverage and limitations.

**Prior Authorization** is a program that monitors prescription drugs to ensure you are getting a medication that is suitable for the intended use and covered by your pharmacy benefit.

If your prescription requires a Prior Authorization, your Physician needs to be consulted to provide additional information before it can be covered under your benefit. The pharmacist's computer will have the phone number for the Pharmacy Benefits Manager who then will speak with your Physician. Only your Physician can provide this necessary information to ensure the prescription is dispensed safely and for the appropriate conditions. If your Physician confirms that the clinical criteria are satisfied, the prescription can be filled under your benefit coverage. If the clinical criteria are not satisfied, the claim is not covered under your benefit. The Pharmacy Benefits Manager will contact your pharmacist and will also send you a letter describing the reasons for denial and provide instructions if you wish to appeal this denial.

The following are examples of medications/drug categories that may require Prior Authorization. The following is not a complete list and may change over time.

- (1) Acne Topical Products
- (2) Asthma – Combination Inhalers
- (3) Bipolar

- (4) Blood Clots
- (5) Cancer
- (6) CAPS (Cryopyrin-Associated Periodic Syndromes)
- (7) COPD (Chronic Obstructive Pulmonary Disease)
- (8) Diabetes
- (9) Dry Eye
- (10) Emphysema – alpha 1 Proteinase Inhibitors
- (11) Growth Hormones
- (12) Hepatitis
- (13) Hereditary Angioedema
- (14) Immune Globulins
- (15) Macular Degeneration
- (16) Metabolic Disorders
- (17) Migraine
- (18) Multiple Sclerosis
- (19) Opiate Addiction
- (20) Opioids
- (21) Osteoarthritis - Hyaluronic Acid Derivatives
- (22) Osteoporosis
- (23) Preterm birth
- (24) Psoriasis
- (25) Red Blood Cell Stimulants
- (26) Rheumatoid Arthritis
- (27) RSV (Respiratory Syncytial Virus)
- (28) Seizure
- (29) Sleep Disorder
- (30) Specialty Medications
- (31) Testosterone
- (32) Topical Pain killer
- (33) White Blood Cell Stimulants

**Drug Quantity Management** is a program designed to make your prescription drugs safer and more affordable. Drug Quantity Management does not deny access to the medication, it will only provide quantities according to the medical guidelines. Drug Quantity Management ensures that the doctor is prescribing your medication at a dose and

quantity considered safe and effective according to guidelines from the U.S. Food & Drug Administration (FDA).

When you submit your prescription, your pharmacist sees a message on the computer system indicating that the quantity is exceeding the maximum allowed. This message will also include quantity which would be covered under your benefit. The pharmacist can then dispense this quantity which is covered under your benefit. Your Physician can request an approval to dispense the original amount and strength prescribed. If the reasons for a higher quantity meet the criteria, an approval is put into the computer system and you can receive the original quantity prescribed.

The following are examples of medications/drug categories that may be limited under Drug Quantity Management. The following is not a complete list and may change over time.

- (1) Allergy
- (2) Antifungals
- (3) Anti-infectives
- (4) Asthma
- (5) Blood cell deficiency
- (6) COPD (Chronic Obstructive Pulmonary Disease)
- (7) Diabetes
- (8) Hepatitis
- (9) High cholesterol
- (10) High blood pressure
- (11) Hormone Supplementation
- (12) Hypnotic – sleep aids
- (13) Inflammatory Conditions
- (14) Influenza
- (15) Migraine Headaches
- (16) Multiple Sclerosis
- (17) Osteoporosis
- (18) Overactive Bladder
- (19) Pain medications – narcotic and non-narcotic agents
- (20) Pulmonary Hypertension
- (21) Rheumatoid Arthritis

## (22) Ulcers

**Step Therapy** is a program that requires for certain prescribed medications that you try a clinically effective, lower-cost medication (Step 1) before using a higher-cost medication (Step 2). Within specific therapy classes, there are often multiple drugs available to treat the same condition and have very similar side effects. The costs for these drugs, however, can vary significantly. Physicians have reviewed these medications and determined, in most cases, they are interchangeable. The Step Therapy program will require that you try a clinically effective, lower-cost medication (Step 1) before using a higher-cost medication (Step 2). If a trial with the Step 1 medication was not appropriate for you, your Physician can request approval to use a Step 2 medication.

The first time you submit a prescription for a Step 2 medication, your pharmacist will inform you that an authorization is required. Your pharmacist's computer will have the phone number for the Pharmacy Benefits Manager who will then speak with your Physician. Only your Physician can provide the necessary information regarding your experience with the Step 1 medications to permit coverage of the Step 2 medication. If your Physician confirms that the Step 1 medication is not appropriate for you, the prescription for the Step 2 medication can be covered under your benefit. Examples why a Step 1 medication may not be appropriate for you include a previous unsuccessful trial or an allergy to the Step 1 medication. If the criteria are satisfied, the Pharmacy Benefits Manager will contact your pharmacist to approve your prescription. If the criteria are not satisfied, the claim is not covered under your benefit. Your Physician may change the prescription to a Step 1 medication which is covered under your benefit. Your pharmacist will be contacted and will then fill the prescription with this approved medication. Similar to the Prior Authorization process, you can appeal the denial.

The following are examples of medications/ drug categories that may require Step Therapy. The following is not a complete list and may change over time.

- (1) ADHD

- (2) Alzheimer's
- (3) Angiotensin Receptor Blockers
- (4) Antidepressants
- (5) Bisphosphonates
- (6) COX-2 Agents
- (7) Hypnotics – sleep aids
- (8) Inhaled Corticosteroids
- (9) Lipid/Cholesterol - HMG agents
- (10) Migraine headache – Triptans
- (11) Nasal Steroids
- (12) NSAIDs (Non-steroidal anti-inflammatory agents)
- (13) Overactive Bladder
- (14) Pain – long acting opioids
- (15) Parkinson's medications
- (16) Specialty medications
- (17) Seizure medications
- (18) Tetracyclines
- (19) Topical Acne products
- (20) Topical Steroids
- (21) Topical Immunomodulators
- (22) Ulcers - PPIs (Proton Pump Inhibitors)
- (23) Uric Acid medications

**F. Limitations for Prescription Drug Coverage**

Prescription Drug benefits will not include and no benefits will be paid for:

- (1) drugs or medicines that are not for a covered illness or injury or which are not approved by the FDA for the Treatment of that illness or injury;
- (2) drugs or medicines that are an Experimental or Investigational Measure;
- (3) drugs or medicines that can be purchased without a Physician's prescription (except those listed under Covered Charges);

- (4) any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date;
- (5) any part of a charge for drugs or medicines that exceed the Retail Network Pharmacy costs;
- (6) drugs or medicines for DESI (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness);
- (7) infertility medications;
- (8) biological sera, blood, blood plasma, or any prescription directing parenteral administration or use;
- (9) drugs or medicines dispensed by a Hospital, Skilled Nursing Facility, Home Health Care Agency, rest home, or other institution in which a Covered Person is confined;
- (10) drugs or medicines, or any other method, to restore fertilization or promote conception;
- (11) drugs or medicines to induce abortion;
- (12) drugs or medicines provided for Cosmetic purposes;
- (13) nonprescription vitamins and minerals;
- (14) nutritional and diet supplements, unless to sustain life and approved by Us;
- (15) diet or appetite suppressants, except when related to an illness and approved by Us;
- (16) contraceptives, except when related to an illness and approved by Us;
- (17) sexual dysfunction, except when related to an illness and approved by Us;
- (18) drugs or medicines prescribed for Treatment leading to, in connection with or resulting from sexual transformation, intersex surgery, or transsexualism;
- (19) anabolic steroids, except when related to an illness and approved by Us;
- (20) any drug or medicine to promote hair growth;
- (21) devices or appliances, support garments, and other non-medicinal substances, regardless of intended use;

- (22) drugs or medicines prescribed or dispensed by any person in your Immediate Family or any person in your Dependent's Immediate Family;
- (23) drugs or medicines purchased outside the United States unless the Covered Person is outside the United States for one of the following reasons:
- (24) travel, provided the travel is:
  - (a) for a reason other than securing medical or dental care diagnosis or Treatment;
  - (b) a business assignment by a covered Employer;
  - (c) the Employee is employed by a covered Employer and working outside the United States; or
  - (d) an eligible Dependent child attending school outside the United States.
- (25) drugs or medicines for which you or your Dependent have no financial liability or that would be provided at no charge in the absence of coverage or that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law) unless charges are imposed against the Covered Person for such drugs or medicines;
- (26) drugs or medicines provided as the result of an injury arising out of or in the course of any self-employment for wage or profit;
- (27) drugs or medicines provided as the result of a sickness covered by a Workers' Compensation Act or other similar law;
- (28) drugs or medicines provided as the result of a sickness or injury that is due to war or act of war or to voluntary participation in criminal activities; or
- (29) drugs or medicines purchased after termination of coverage under This Plan.

## **G. How to Order From the Mail Order Pharmacy**

Your initial order consists of three parts: the written prescription from your Physician; a Patient Profile order form ; and a Copayment. These are described below. You should allow 14 days for your order to be completed and shipped to you. All orders are shipped either by UPS or First Class U.S. Mail.

### **1) The Written Prescription**

When obtaining your prescription, be sure to ask your Physician to specify the following information:

- (1) patient name;
- (2) 90 day supply of medication (the Physician should indicate the total number of pills required for that period of time. For example, 270 tablets would be needed for medication that must be taken three times a day.);
- (3) refills (Many Maintenance Drugs can be prescribed for up to one year; therefore, a prescription for a 90 day supply may specify up to three refills.); and
- (4) Physician's signature.

### **2) Patient Profile Order Form**

You will also need to complete the Patient Profile Order Form and send it to the mail order pharmacy with each order. The Patient Profile Order Form provides information concerning eligibility in addition to health and allergy conditions pertaining to each Covered Person.

### **3) Copayment and/or Deductible**

Any Copayment and/or Deductible must accompany each order. The Copayment and/or Deductible amount is described in your Summary of Benefits and Coverage.

### **4) Refills or Follow-up Orders**

Each filled order you receive includes Refill Ordering Instructions and a Patient/Profile Order Form. Orders for refills should be placed ap-



proximately two weeks before the current supply or medication is expected to run out. You may also be able to place refill orders via the internet.

### 5) *Special Situations*

If a Maintenance Drug is prescribed for immediate use, you should obtain two prescriptions--one for a 30 day supply to be filled immediately at a local pharmacy, and a second one for a 90 day supply with refills, to be filled by the Home Delivery Pharmacy if and when the medication proves satisfactory.

### 6) *Questions*

If you have a question concerning your prescriptions, you can call the Pharmacy Benefits Manager. You can also call the toll-free number on the Patient Profile Order Form.

Also included with each order filled by the mail order pharmacy is a Patient Counseling information sheet which has specific information about the medication included with the order.

## H. **Prescription Appeal Procedures**

If you or the pharmacist have a question about a prescription which cannot be filled at the pharmacy, either you or the pharmacist should contact the Pharmacy Benefits Manager at the telephone number listed on your identification card.

If the prescription cannot be filled because pre-authorization is required, you should have the ordering Physician contact the Pharmacy Benefits Manager.

### 1) *Coverage review description*

A Covered Person has the right to request a medication be covered or be covered at a higher benefit (e.g., lower Copayment, higher quantity, etc.). The first request for coverage is called an initial coverage review. The Pharmacy Benefits Manager reviews both clinical and administrative coverage review requests.

**Clinical Coverage Review Request** means a request for coverage of a medication based on clinical conditions of coverage that are set by

This Plan. For example, medications that require a Prior Authorization.

### 2) *How to request an Initial Coverage Review*

The preferred method of requesting an Initial Coverage Review is for the prescriber or dispensing Pharmacist to call the Pharmacy Benefits Manager Initial Coverage Review Department.

Home Delivery coverage review requests are automatically initiated by the Pharmacy Benefits Manager as part of filling the Prescription.

If the patient's situation is urgent, an Urgent Review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of the request

An urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by the provider by phone.

A decision regarding your Initial Coverage Review will be sent to you within 15 days of receipt of your request.

### 3) *How to request a Level 1 Appeal*

When an Initial Coverage Review has been denied (Adverse Benefit Determination), You may request an appeal within 180 days from receipt of notice of the initial Adverse Benefit Determination. To initiate a Level 1 Appeal, the following information must be submitted by mail or fax to the Pharmacy Benefits Manager Level Appeals Department:

- (1) Name of patient;
- (2) Employee ID;
- (3) Phone number;
- (4) The drug name for which benefit coverage has been denied;
- (5) Brief description of why the claimant disagrees with the initial adverse benefit determination; and

- (6) Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or Treatment that is the subject of the claim.

Urgent appeals must be submitted by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent

#### **4) How to request a Level 2 Appeal**

When a Level 1 Appeal has been denied, you may request a Level 2 Appeal within 90 days from your receipt of notice of the Level 1 Appeal Adverse Benefit Determination. To initiate a Level 2 Appeal, the following information must be submitted by mail or fax to Pharmacy Benefits Manager Appeals Department:

- (1) Name of patient
- (2) Employee ID
- (3) Phone number
- (4) The drug name for which benefit coverage has been denied
- (5) Brief description of why the claimant disagrees with the adverse benefit determination
- (6) Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

An urgent Level 2 Appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or Treatment that is the subject of the claim.

Urgent appeals must be submitted by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

#### **5) External Review**

You have the right to request an independent external review of an Adverse Benefit Determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving Treatment that is considered an Experimental or Investigational Measure. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an Independent Review Organization with experts who were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to the Pharmacy Benefits External Review Coordinator. The request must be received within 4 months of the date of the final Internal Adverse Benefit Determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

The Pharmacy Benefits External Review Coordinator will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and the patient will be notified within 1 business day following the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the Pharmacy Benefits Manager for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, This Plan and Pharmacy Benefits Manger written notice of

its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

### **6) Urgent External Review**

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one, where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life, health or the ability of the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or Treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

### **I. Coordination with Other Benefits – Prescription Drugs**

Your Prescription Drug program does not coordinate benefits with any other plan or program nor will reimbursements be made for drugs purchased through other coverage, except where applicable by law.

#### **1) Reimbursement/Subrogation**

If This Plan provides any benefits in connection with a Claim by a Covered Person, the Covered Person shall reimburse This Plan, to the extent of all amounts that This Plan has paid, from any amounts that the Covered Person recovers from any source other than This Plan in connection with the Claim. The Covered Person's recovery from a source other than This Plan shall not be reduced by the amount of the Covered Person's attorney fees or for any other reason whatsoever, until This Plan has been repaid in full.

In addition, This Plan shall be subrogated to any legal rights which the Covered Person may have to recover against any party in connection with the Claim.

This reimbursement/subrogation provision applies to recoveries available to minor children from sources other than This Plan.

By accepting benefits under This Plan, the Covered Person hereby grants a lien and assigns to This Plan an amount equal to the benefits paid against any recovery made by or on behalf of the Covered Person. The assignment is binding on any attorney who represents the Covered Person whether or not an agent of the Covered Person and on any insurance company or other financially responsible party against whom a Covered Person may have a claim provided said attorney, insurance carriers or others have been notified by This Plan or its agents.

The Covered Person shall notify timely This Plan of any litigation, settlement discussions, or other efforts to recover amounts from sources other than This Plan in connection with the Claim. A Covered Person shall obtain approval from This Plan before releasing any rights to recover medical and/or prescription drug expenses from sources other than This Plan.

If This Plan establishes that a Covered Person, personally or through the acts of an agent or attorney, breaches obligations under this provision, This Plan shall be entitled to pursue and recover all available remedies together with any and all costs, including reasonable attorney fees, that This Plan may incur in establishing the breach and in obtaining remedies for the breach.

Covered Persons shall comply with all of the requirements within this reimbursement/subrogation provision in order to continue receiving benefits under This Plan.